

**Exploring Mental Health Practitioners' Beliefs About Hope and  
Experiences of Fostering Service Users' Hope Within Community and  
Secure Settings**

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## Preface

The purpose of this preface is to provide guidance to the reader regarding the following three papers.

## Style

Papers 1 and 2 have been written in accordance with publication guidelines for the Journal of Mental Health and Journal of Forensic Psychiatry and Psychology, respectively (full author guidelines are included within the Appendices). Some minor amendments have been made to style and layout (e.g. font size and spacing) in order to maintain consistency and to aid readability across the thesis as a whole. These changes will be rectified prior to journal submission. To aid the reader, direct participant quotes are presented in “*double*” quotation marks and citations from text are presented in ‘*single*’ marks. Themes and categories are *italicised* throughout.

## Language and Terminology

Participants in the empirical study used different terms to refer to the individuals they worked with, with some voicing a strong preference for the use of the term ‘patient’. In accordance with recent guidance from the British Psychological Society and Division Of Clinical Psychology (DCP) (BPS, 2015) the terms ‘service user’ or ‘client’ are used throughout this thesis (with the exception of direct quotes and citations, where original terminology is retained).

**Secure services.** The terms *secure* and *forensic* services/settings are used interchangeably throughout this thesis. The following contextual information is taken from the NHS England Standard Contract for medium and low secure mental health services (adults) (Service specification number C03/S/a, 2013/14) and reports by the Centre for Mental Health (2011) and Joint Commissioning Panel for Mental Health (2013).

Secure mental health services provide accommodation, care and support for people with severe and often complex mental health difficulties

who pose a risk of harm to others that cannot be managed safely within other mental health settings. Individuals may also have co-morbid substance use and personality related difficulties, which are linked to offending behaviour. Most individuals are admitted from court or prison and many have Ministry of Justice restrictions imposed. The services operate on three levels of security: high, medium and low. The empirical study described in Paper 2 was conducted within a medium secure service comprised of separate acute and rehabilitation wards and an intensive care unit (ICU). All individuals admitted to medium secure services are detained under the Mental Health Act (1983 amended in 2007). The aim of secure services is to help the service user access evidence-based clinical and risk interventions and move along their care pathway: either returning to prison, moving to conditions of lesser restriction, step-down/supported accommodation or accessing support from community-based forensic mental health services. 'My Shared Pathway' (MSP) was introduced in 2012/13 to support the implementation of the recovery model, plan and deliver care in low and medium secure settings.

## **Literature Review**

There is on-going debate regarding the completion of the literature review within grounded theory research (see Dunne, 2011). Glaser and Strauss (1967) and Glaser (1998) explicitly argued that the literature review should not be carried out until after study completion. Dunne (2011) stated that researchers should make the decision about when to complete the literature review early in the research process and outline their choice clearly. In the current thesis, the decision was made to fully review the literature mid-way through the analysis process, once some tentative categories had been developed. This decision was based partly on practical necessities; however it was also felt that delaying the review prevented the researcher from forcing pre-existing theoretical frameworks on to the data whilst helping the researcher to contextualise the study and providing possibilities, connections and questions to remain sensitive to within the data (Charmaz, 2014).

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## Thesis Abstract

Hope has been linked to psychological well-being, resilience and recovery from mental health difficulties. Many recovery-oriented policies have included calls for mental healthcare staff to develop hope-inspiring relationships with their clients. However, guidance and research regarding the clinical application of these recommendations are lacking. This is particularly the case within forensic mental health services, which have been slower to adopt the recovery model. This thesis aimed to develop an understanding of staff perspectives about hope and their experiences of fostering hope with service users, in forensic mental health settings. An initial scoping exercise found that no such studies have been conducted in secure settings. Therefore, Paper One reports a review of qualitative literature exploring staff beliefs of hope, practices to foster hope and the challenges faced by practitioners across a broad range of mental health settings. The therapeutic relationship, helping the client to maintain social connections, uncovering values and goals and working to develop different perspectives emerged as important hope-inspiring practices. Clinicians identified the importance of maintaining their own sense of hope and also the challenges to remaining hopeful. Many of the studies lacked an integration of the themes and categories that emerged from analysis. Paper Two reports an empirical study that utilised a Grounded Theory methodology to develop a model of nurses' experience of inspiring hope in their clients within one medium secure hospital. The grounded theory that was developed from the data described what it meant for the nurses to *hold on to hope* for their clients. Two categories (*being the intervention* and *doing reasonable hope*) captured the practices through which nurses worked to foster hope. These practices were influenced by the nurses' beliefs about hope and the context of the secure unit. The model also captured the *emotional impact* of working to inspire hope and the way in which nurses managed their emotional response. The clinical implications of the findings, particularly to staff recruitment, training and support, are discussed. Paper three outlines the author's own reflections on the research process.

**Thesis word count 21, 418**

## **Paper 1**

### **What Are Practitioners' Beliefs About Hope and How Do They Work To Foster It With Service Users in Mental Health Settings? A Review of the Literature**

This paper has been written broadly in line with the guidelines for the Journal of Mental Health (please see Appendix 1 for full guidelines)

**Word count:** 6, 375 (exclusive of abstract, tables, figures and references)

## **Abstract**

**Background.** Hope has been described as an energising and healing force (Groopman, 2004), which helps individuals to cope with mental health difficulties (Lazarus, 1999). Inspiring hope should be a guiding principle for recovery-oriented mental health professionals (National Institute for Mental Health England; NIMHE, 2005). A paucity of research has focussed on the perspectives of staff.

**Aims.** This article reviews practitioners' beliefs about hope, how they aim to facilitate hope in their work and any challenges to inspiring hope.

**Method.** A review of published, empirical literature was conducted to identify all studies of hope from the perspective of staff in mental health related settings. Articles were summarised and findings analysed.

**Results.** Beliefs about hope reflected the existing literature. Several hope-fostering strategies were identified, with a particular emphasis on the therapeutic relationship. Challenges were acknowledged, particularly around staff maintaining a personal sense of hope.

**Conclusions.** Staff working in mental health settings view the development of hope with their clients as important and utilise a range of strategies to facilitate hope. It is imperative that staff have support to manage their own level of hope. Further research is needed, particularly in settings where practitioners may face increased challenges in developing hope with service users and maintaining their personal sense of hope.

**Declaration of interest.** None

**Keywords.** Hope, staff, mental health, beliefs.

## **Background**

### **Conceptualisations of Hope**

Hope has been written about from a huge variety of theoretical and philosophical perspectives. Many writers have conceptualised hope as an essential '*life force*' or '*basic feature of human consciousness*' (e.g. Bloch 1986; Frankl, 1942; Marcel, 1944; in Elliott, 2005). The psychiatrist Karl Menninger (1959) was one of the first to emphasise the role of hope in psychological growth and well-being, yet also highlighted a need for further research into mental health and hope.

Since then, many different definitions and conceptualisations of hope have emerged across the health sciences (see Elliott, 2005 and O'Hara, 2013 for comprehensive reviews). Snyder (1995, 2002) developed a widely cited theory of hope as a primarily cognitive phenomenon, based on the identification of goals and development of pathways to achieve them. Others have suggested that hope is a multi-dimensional construct (e.g. Dufault & Martocchio, 1985). In a systematic review Schrank, Stanghellini and Slade (2008) proposed that hope is comprised of affective, cognitive, behavioural and environmental components. However Nikolaichuk, Jevne and Maguire (1999) suggested that formal conceptualisations fail to capture the intangible qualities of hope bound up in unique individual experiences. They emphasised that hope is experienced in the context of a genuine, caring relationship, which connects to psychodynamic and attachment perspectives of hope. For example, Erikson (1964/1994) suggested that hope is the first '*virtue*' or strength to develop during infancy, in the context of a relationship with a trustworthy and responsive maternal figure.

### **Importance of Hope to Mental Health**

There is a well-established relationship between hopelessness, depression and suicidal ideation/intent (e.g. Beck, Kovacs & Weissman, 1975; Beck, Steer, Beck & Newman, 1993). The positive psychology approach has given greater priority to valued subjective experiences or traits, including hope, to explore factors that promote well-being and enhance resilience to psychological distress (Seligman & Csikszentmihalyi, 2000).

Schrank et al. (2008) stated that it is difficult to summarise research into the impact of hope on outcomes from mental health difficulties, given the different definitions and conceptualisations of hope employed. However, several reviews have summarised what helps service users to feel hopeful and interventions used with the intention of fostering hope (e.g. Cutcliffe & Herth, 2002; Cutcliffe & Koehn, 2007; Koehn & Cutcliffe, 2007; Kylmä et al., 2006; Schrank et al., 2008; Vass, 2011). At the very minimum, it can be stated that hope did not have a detrimental impact on service users. Furthermore, across several studies enhancing hope had a positive impact on perceived coping abilities and a range of mental health difficulties including depressive symptoms, anxiety and overall distress (Schrank et al., 2008).

Over recent years hope has also been contextualised as one of the key elements in the recovery model (Shepherd, Boardman & Slade, 2008; Slade, 2009). Recovery has been defined as a *'deeply personal process, with a focus on developing new meaning and purpose in one's life in order to grow beyond the impact of mental illness'* (Anthony, 1993, p.14). Hope has emerged as a key theme in service users' accounts of recovery from a range of mental health difficulties (Bonney & Stickley, 2008; Deegan, 1988; Marino, 2014) whilst hopelessness has been found to restrict recovery (Soundy et al., 2015). Evaluating the effect of the recovery model within mental health services is challenging (Green, Batson & Gudjonsson, 2011). However Warner (2010) cites support for recovery principles, such as empowerment and social inclusion, in improving functioning and quality of life following psychological difficulties.

### **Inspiring Hope in Mental Health Settings**

Several policy documents include proposals that inspiring hope should be seen as a guiding principle or skill of recovery oriented staff working within mental health (e.g. Maddock & Hallam, 2010; NIMHE, 2005; Repper & Perkins, 2003; Shepherd et al., 2008). A small number of studies have begun to explore how staff in these settings can develop hope in the individuals they work with and have identified hope-fostering 'strategies' or



practices for this purpose (e.g. Borg & Kristiansen, 2004; Hobbs & Baker, 2012). Very little research has focussed on staff perspectives of hope and inter-personal practices to foster hope (Spandler & Stickley, 2011). Koehn and Cutcliffe (2007) (see also Cutcliffe & Koehn, 2007) reviewed studies exploring staff perspectives of hope between 1980 and 2005, although these studies were limited to mental health or psychiatric nurses and conflated staff and service user perspectives. O'Hara (2013) has also recently summarised hope-instilling strategies identified by mental health clinicians across the literature. However this summary is drawn from a small number of studies and offers no critical review of the research.

### **Aims and Objectives**

This review aimed to explore what is known about practitioner perspectives of hope and strategies utilised to foster hope with service users, in general mental health settings. The quality and methodological rigour of the studies included in the review was also assessed.

### **Method**

The literature review was conducted in a systematic, clear and comprehensive manner (following Aveyard, 2014). The literature search was conducted in July 2014. The meta-search engine EBSCOhost was used to access the following databases: Academic Search Complete (ASC), Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE and PsychInfo. In addition the NHS Evidence Health Databases Advanced Search (HDAS) service was used to access the British Nursing Index (BNI) and EMBASE database. The meta-search engine ProQuest was used to access the Applied Social Sciences Index and Abstracts (ASSIA) database. Databases were searched individually in order to utilise the specific functions of each.

## **Inclusion and Exclusion Criteria**

Papers were included only if:

- Practitioners were working directly with service users experiencing mental health difficulties or in settings where there was a predominant focus on mental health issues
- The main subject of the paper was staff views or beliefs about hope; and views, beliefs or experiences of working to instil hope with service users
- Papers used a qualitative methodology, in order to best capture personal beliefs about hope and experiences of fostering hope
- Papers were peer reviewed and published in an empirically-based journal
- Published in 1995 or later, in line with an increased focus on recovery from mental health difficulties (e.g. Davidson & McGlashan, 1997) following the implementation of the National Health and Community Care Act (1990) and emergence of first person accounts of hope and recovery (e.g. Anthony, 1993; Deegan, 1996)
- Written or available in English

Paper were excluded if:

- The sole focus was service user, family or care-giver views
- The predominant focus was on physical health issues

## **Search Strategy**

The terms 'hope' OR 'hope\*' were limited to title or major subject heading (or equivalent) only. The term 'hope' alone was used due to the subtle conceptual differences noted between hope and related terms (e.g. 'optimism'; see Bruininks & Malle, 2005). All other search terms were extended to include the abstract. The following search terms were used: 'staff' OR 'nurs\*' OR 'worker' OR 'professional' OR 'clinician\*' OR 'therapist\*' OR 'practitioner\*' AND 'mental\*' OR 'psychol\*' OR 'psychiatr\*' OR 'counsel\*' AND 'belief\*' OR 'attitude\*' OR 'view' OR 'perspective\*' OR 'inspir\*' OR 'instil\*' OR 'giv\*' OR 'facilitat\*' OR 'enabl\*' OR 'support\*' OR 'develop\*'. The development of search terms was aided by consultation of other relevant search strategies (e.g. Schrank et al., 2012).

The initial search resulted in a total of 410 papers once duplicates were removed. Papers were screened using a three-stage process based on the inclusion and exclusion criteria. Initially papers were screened by title or by accessing the abstract. The full text was accessed when the eligibility of the paper remained unclear. Seven papers met the eligibility criteria and were accessed for inclusion in the review. The search was strengthened by additional hand-searching of included papers, review articles and relevant books. Potentially relevant articles were subjected to the screening process, resulting in the inclusion of five more papers. Database software was managed in order to alert the researcher to any newly acquired or recently published peer-reviewed journal articles meeting the search strategy, over a three-month period following the initial search. Results were screened following the same three-stage process outlined previously. One further article was subsequently retrieved.

Thirteen papers were accessed and met the inclusion criteria. Two sets of papers were collated (Cutcliffe 2004; Cutcliffe, 2006a, 2006b and Larsen & Stege, 2010a, 2010b) as in each case, the papers referred to one empirical study. A total of ten studies were therefore reviewed. All of the papers included in the review utilised a qualitative methodology, in order to capture the personal and individual nature of hope (Nekolaichuk et al., 1999). The full search strategy and screening process are clearly outlined in Figure 1.

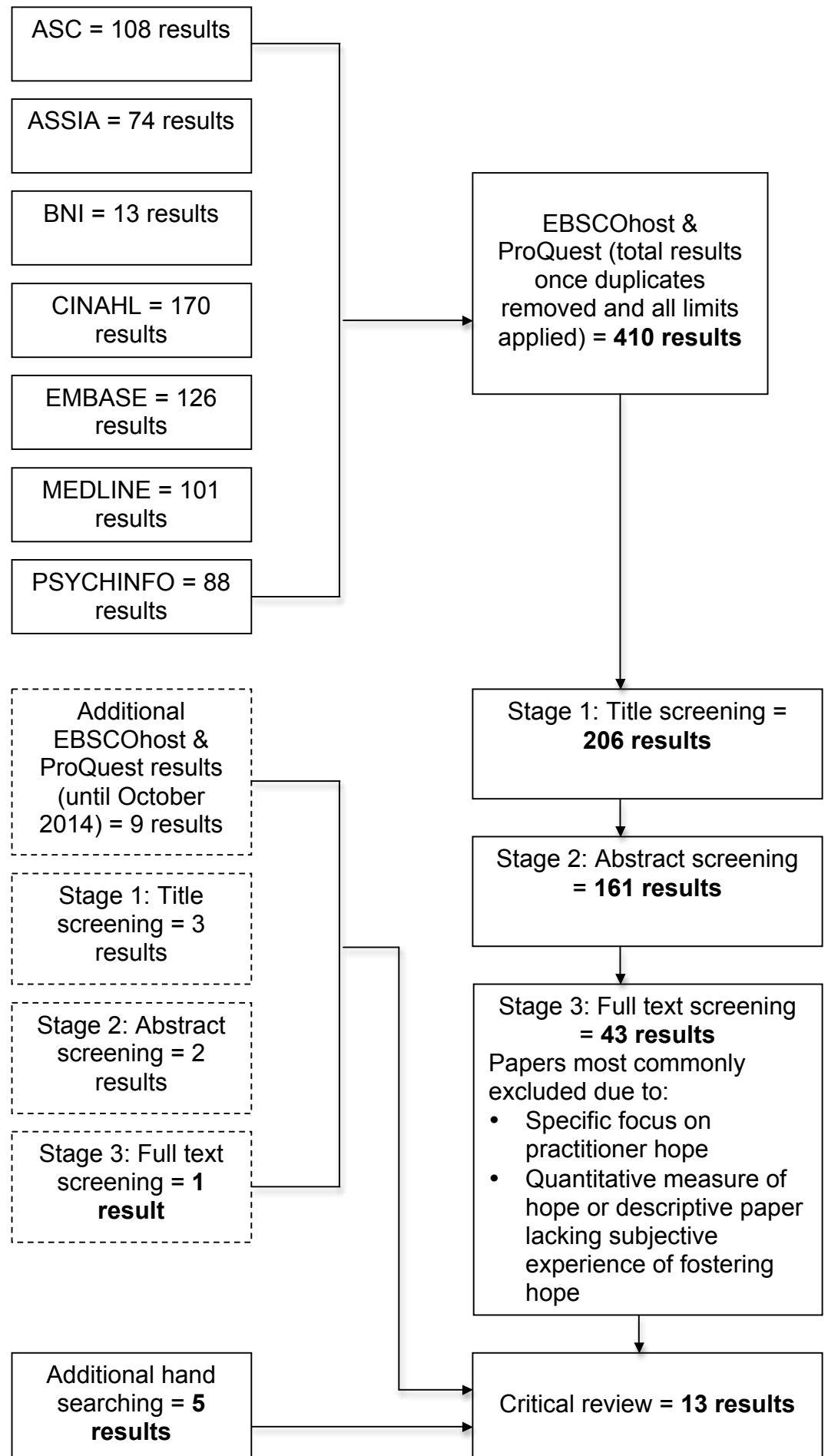


Figure 1 Literature review search strategy flowchart

## Data Analysis

Included articles were entered into a database describing the study design, methodology and main findings to allow for critical review (see Table 1 for an overview of included papers). The review was carried out utilising a set of 13 questions to assess the quality and methodological rigour of each paper (see Appendix 2). Questions were developed through the amalgamation of items from two published checklists: the Critical Appraisal Skills Programme checklist for qualitative studies (CASP, 2014) and guidelines for reviewing qualitative research (Elliott, Fischer & Rennie, 1999).

The analysis allowed for the identification of common themes across the papers reviewed. Initially, all identified themes and categories (and any sub-themes or variables) were entered into a database. Themes were then grouped according to similarities (in accordance with guidelines by Thomas & Harden, 2008). New codes were developed by the researcher to capture the meaning of grouped themes and compared to original themes to ensure that they were accurately reflected in the data. This process resulted in 12 descriptive themes captured under the broad headings *beliefs about hope*, *facilitating hope* and *challenges to hope*.

Table 1 Summary of papers included in the review

Study	Setting	Participants	Aims/objective	Methodology/design	Summary of main findings
<b>Cutcliffe (2004, 2006a, 2006b)</b>	Several community based services UK	8 bereavement counsellors (5 male, 3 female) and 4 ex-clients who had previously received bereavement counselling (2 male, 2 female)	To answer the question 'Do bereavement counsellors inspire hope in their clients, and if so, how?'	Unstructured interviews; 'modified' Grounded Theory following Glaser and Strauss's (1967) approach	An integrated theory of the inspiration of hope in bereavement counselling through different phases. The theory was comprised of one core variable ' <i>The implicit projection of hope and hopefulness</i> ' and three sub-core variables: ' <i>Forging the connection and relationship</i> '; ' <i>Facilitating a cathartic release</i> ' and ' <i>Experiencing a healthy (good) ending</i> '
<b>Cutcliffe &amp; Grant (2001)</b>	Hospital based continuing care unit UK	5 Registered Mental Health Nurses (2 male, 3 female)	To identify the processes of inspiring hope in cognitively impaired older adults within a continuing care environment, in order to provide insight and the development of new care approaches to this client group	Semi-structured interview; Grounded Theory utilising Glaser and Strauss's (1967) approach	An integrated theory of hope-inspiration within this client group accounted for the translation of the nurse's values into the client's needs. The central core variable ' <i>Applied Humanistic Code</i> ' subsumed three other core variables: ' <i>Pragmatic Knowledge</i> ', ' <i>Interpersonal Relations</i> ' and ' <i>Nurse as Utiliser</i> '
<b>Darlington &amp; Bland (1999)</b>	Community mental health service Australia	6 mental health workers (5 female, 1 male) and 6 consumers of mental health services (2 female, 4 male)	To explore the mental health worker's role in encouraging and sustaining a sense of hope in people with serious mental illness	Semi-structured interviews; appears that data was analysed using some kind of thematic analysis	Five main hope-fostering strategies: ' <i>Working within the client's frame of reference</i> '; ' <i>Focussing on the client's strengths</i> '; ' <i>Making links to past gains</i> '; ' <i>Being human</i> '; and ' <i>Having hope that change is possible</i> '. Both participant groups identified the staff-service user relationship as important to hope

Study	Setting	Participants	Aims/objective	Methodology/design	Summary of main findings
<b>Kirkpatrick, Landeen, Byrne, Woodside, Pawlick &amp; Bernardo (1995)</b>	Hospital and community-based services for individuals with a diagnosis of schizophrenia Canada	15 multi-disciplinary staff members (gender not specified)	Part of a wider study to better understand staff perspectives on the relationship between hope and schizophrenia; this study focussed on staff understanding of hope and how staff believed that they could influence the hopefulness of their clients	Interviews; methodology not clear but seems to be based on content analysis	Themes were divided into ' <i>hope-instilling strategies</i> ' and ' <i>obstacles to hope</i> '. Five strategies identified: ' <i>Building relationships</i> '; ' <i>Facilitating success</i> '; ' <i>Connecting to successful role models</i> '; ' <i>Managing the illness</i> '; ' <i>Educating clients and the community</i> '
<b>Koehn &amp; Cutcliffe (2012)</b>	Private community-substance misuse services Canada	7 substance abuse counsellors (3 male, 4 female); 3 individuals with previous experience of engaging with substance use services (2 male, 1 female)	To explore how hope contributes to the recovery process in people with substance use problems. Key research questions: Do substance abuse counsellors inspire hope in their clients? If so, how?	Semi-structured interviews; Grounded Theory (modified version of that outlined by Glaser, 1998; Glaser & Strauss, 1967)	One overarching core category emerged, ' <i>Actively creating a different vision with the client</i> '. This cut across three mutually influential, psychosocial phases of hope-inspiration during the counselling journey: ' <i>Developing a non-judgemental bond</i> '; ' <i>Self, relationships and the future</i> '; ' <i>Shaking it up</i> '; ' <i>Reviewing pathways to hope to facilitate endings</i> '
<b>Larsen &amp; Stege (2010a, 2010b)</b>	Community research and counselling facility Canada	5 psychologists (all female) and 11 clients (5 male, 6 female)	Paper 1 explored implicit hope-focused interventions (practices not using the word 'hope' specifically). Paper 2 explores explicit hope-focussed interventions	Case study methodology utilising a video recording of a single therapy session and an interview with each participant using Interpersonal Process Recall (IPR)	Two over-arching implicit hope-inspiring categories: ' <i>The therapeutic relationship</i> ' and ' <i>Perspective change</i> '. Explicit hope interventions in the study were represented in five key dimensions: <i>cognitive, behavioural, temporal, embodied/emotional and relational</i>

Study	Setting	Participants	Aims/objective	Methodology/design	Summary of main findings
<b>McCann (2002)</b>	Community mental health service Australia	9 clients with experience of an early episode of psychosis; 8 significant others (7 parent, 1 partner) and 24 community mental health nurses (gender not specified)	To explain the processes that mental health nurses use to enable young adult clients who have schizophrenia to have hope for the future	Unstructured interviews, field observations of nurse-client interaction; guided by Grounded Theory (Strauss & Corbin, 1990, 1998)	Nurses used two main strategies to uncover hope for the future: <i>'Enhancing motivation'</i> (uncovering values and realistic hopes) and <i>'Developing pathways to wellness'</i> (goal-setting and making plans). Central to both was the development of a mutual, trusting relationship
<b>O'Hara &amp; O'Hara (2012)</b>	University; a counselling and psychotherapy association UK	68 counselling students (11 male, 49 female, 5 undisclosed). 11 therapists (2 male, 9 female). All actively involved in providing therapy	To explore how therapists conceptualise hope and how hope is operationalised in therapy	Brief questionnaire featuring open-ended questions; semi-structured interviews; Grounded Theory	Five core categories incorporated several sub-categories: <i>'Nature and source of hope'</i> ; <i>'Hope stance and orientation'</i> ; <i>'Blockages to and difficulties maintaining hope'</i> ; <i>'Dialectic nature of hope and despair'</i> ; <i>'Hope-focussed strategies'</i>
<b>Ward &amp; Wampler (2010)</b>	Community based marriage and family therapy services USA	15 marriage and family therapists (8 female, 7 male)	To provide a clear conceptualisation of hope and develop knowledge of interventions to increase hope in the therapeutic context	Semi-structured telephone interview; Grounded Theory (based on Strauss & Corbin, 1998)	Four properties determined an individual's level of hope: <i>Evidence</i> , <i>Options</i> , <i>Action</i> , and <i>Connection</i> . A central category, <i>'Moving up the continuum of hope'</i> was identified. Three processes of <i>'moving up the continuum'</i> emerged from the data: <i>'Creating a context of hope'</i> ; <i>'Cutting the engine on the freight train'</i> (helping to stop negative interactional cycles); and <i>'Getting over the hump'</i> (encouraging a more objective perspective)



Study	Setting	Participants	Aims/objective	Methodology/design	Summary of main findings
<b>Yohani (2010)</b>	Community-based Early Intervention Programme (EIP) Canada	7 multi-disciplinary EIP staff (1 male, 6 female); 5 'educational cultural brokers' (community representatives who facilitate communication with children's schools and families; 2 male, 3 female)	To explore staff perceptions of hope in refugee children and what leads to hope	Case study methodology utilised comprising observations and personal perceptions of the EIP recorded during a 6-month period. Group interviews with staff and educational cultural brokers; Thematic Analysis	Three main themes were discovered that represented how staff see hope, based around the metaphor of staff carrying out the work of a ' <i>hope gardener</i> ': ' <i>Hope is like a seed</i> '; ' <i>Invisible seeds: some challenges that hinder hope</i> '; ' <i>Visible seeds: some experiences engender hope</i> '

## Results

The literature search resulted in a total of thirteen papers. Two sets of papers were collated (Cutcliffe 2004; Cutcliffe, 2006a, 2006b and Larsen & Stege, 2010a, 2010b) as in each case, the papers referred to one empirical study. A total of ten studies were therefore reviewed. The studies originated from several countries, with the majority conducted in Canada ( $n=4$ ) and others in the UK ( $n=3$ ), Australia ( $n=2$ ) and the USA ( $n=1$ ). The predominant social norms and healthcare systems across these countries were deemed sufficiently similar to enable comparison. Studies were conducted across a variety of settings including counselling based services and mental health teams, with a variety of multi-disciplinary staff. Where specified, there was a fairly even gender balance. With the exception of Cutcliffe and Grant (2001) and Kirkpatrick et al. (1995) all of the studies took place in community based services. The most frequently used design ( $n=6$ ) was Grounded Theory (GT). GT enables the development of theory for social and psychological processes, particularly when there is little existing literature in an area (Birks & Mills, 2011). As such it is well suited to exploring staff beliefs and practices to instil hope.

### Analytical Themes

The three broad analytical themes and 12 descriptive themes are displayed in Table 2 and outlined below.

Table 2 Results of thematic analysis

Analytical theme	Descriptive themes
Beliefs about hope	Definitions of hope Sources of hope The temporality of hope
Facilitating hope	Clinician characteristics The therapeutic relationship Developing social links and connections Information sharing Developing different perspectives Uncovering values and goals
Challenges to hope	Client challenges Clinician challenges Systemic challenges

## **Beliefs About Hope**

Only two papers (O'Hara & O'Hara, 2012; Ward & Wampler, 2010) included specific questions related to personal meanings of hope. However *beliefs about hope* emerged as a theme through participants' descriptions of working to develop hope, comprising three descriptive themes.

**Definition.** Five studies (Cutcliffe, 2006b; Larsen & Stege, 2010b; McCann, 2002; O'Hara & O'Hara, 2012; Ward & Wampler, 2010) described cognitive and affective elements to hope. For example O'Hara and O'Hara (2012) defined hope as a '*positive feeling or expectancy*'. Ward and Wampler (2010, p. 216) suggested that hope is '*a belief and a feeling that a desired outcome is possible*'. McCann (2002) and Larsen and Stege (2010b) additionally emphasised the '*multi-dimensional*' nature of hope, with the latter identifying behavioural, temporal and relational aspects. Although McCann (2002) provided a specific definition it was unclear whether this was defined prior to the study or emerged from the data. Four papers specified that hope must be achievable, '*possible*' or '*within reach*' (Darlington & Bland, 1999; Koehn & Cutcliffe, 2012; Ward & Wampler, 2010; Yohani, 2010).

Two papers took a slightly different focus, with participants highlighting hope as an essential '*human quality*' (Darlington & Bland, 1999). Hope was described less in cognitive or affective terms but as the means through which essential qualities and values of the practitioner were applied to meet the needs of the client (Cutcliffe & Grant, 2001).

**Sources.** Participants across all papers made reference to the *source* of hope. Four papers identified the client themselves as the *source* of hope, highlighting hope as an intra-personal phenomenon (Darlington & Bland, 1999; Kirkpatrick et al., 1995; McCann, 2002; Yohani, 2010). The use of metaphor reflected this position; for example Kirkpatrick et al. (1995), O'Hara and O'Hara (2012) and Yohani (2010) likened hope to a "*seed*", "*glimmer*" or "*spark*" to "*nurture*" within the person with staff '*facilitating*' or '*assisting*' the process (McCann, 2002; Kirkpatrick et al., 1995).

Participants across all of the papers also identified hope as having an inter-personal or relational dimension. One participant summarised that: *“hope in many ways comes from within [the client], but in other ways we can seed it”* (Kirkpatrick et al., 1995, p.17). All papers highlighted the clinician–service user relationship (from herein referred to as the therapeutic relationship) as a *source* of hope. Other inter-personal *sources* of hope were seen as relationships with family (Larsen & Stege, 2010b; O’Hara & O’Hara, 2012; Yohani, 2010), friends (O’Hara & O’Hara, 2012) and partners (Ward & Wampler, 2010). Participants in the study by Larsen & Stege (2010b) and Yohani (2010) identified the potential for family relationships to have a negative impact on service user hope.

Within three studies *‘spiritual’, ‘religious’* or *‘transcendental’* beliefs were identified as an additional *source* of hope (Koehn & Cutcliffe, 2012; O’Hara and O’Hara, 2013; Ward and Wampler, 2010). Interestingly, Cutcliffe (2004; 2006a, 2006b) highlighted that bereavement counsellors did not identify spirituality or religion as sources of hope.

**Temporality.** Four of the papers reviewed specifically referred to hope as relating to the *‘future’* (O’Hara & O’Hara, 2012) or discussed hope in terms of future goals or pathways (Koehn & Cutcliffe, 2012; Larsen, 2010b; McCann, 2002). However O’Hara and O’Hara (2013) highlighted a divergent view of hope as situated in the present that *‘allows one to accept life as it is currently experienced’* (p.45). Similarly Cutcliffe (2004; 2006a, 2006b) proposed that hope develops in the present through allowing for the cathartic release of emotion and coming to terms with bereavement.

### **Facilitating Hope**

The main focus of papers included in the review was how practitioners worked to inspire hope within their clients. The second analytical theme, labelled *facilitating hope*, comprised six themes that described the hope-inspiring practices identified across the papers.

**Clinician characteristics.** The practitioner's '*own hope*' (Cutcliffe, 2004; Larsen & Stege, 2010a; O'Hara & O'Hara, 2012; Ward & Wampler, 2010) or '*hopeful orientation*' (Yohani, 2010) emerged as an important factor in facilitating hope. Several participants spoke of the need for the clinician's hope to be "*genuine*" (Darlington & Bland, 1999; Cutcliffe & Grant, 2001; Koehn & Cutcliffe, 2012; Yohani, 2012). Practitioners' personal hope was seen as important in helping to "*hold on to*", '*carry*' or '*transplant*' a sense of hope into the service user (Cutcliffe, 2004; Darlington & Bland, 1999; O'Hara & O'Hara, 2012); alternatively the service user was encouraged to "*borrow*" the clinician's hope (Larsen & Stege, 2010a; Ward & Wampler, 2010).

Participants highlighted the need to be "*non-judgemental*" (e.g. Koehn & Cutcliffe, 2012). Other qualities required to inspire hope included being "*caring*", "*patient*", "*encouraging*", "*empathic*" and using "*humour*" (Cutcliffe & Grant, 2001; Koehn & Cutcliffe, 2012; Larsen & Stege, 2010a; Yohani, 2012).

**Therapeutic relationship.** Practitioners across all of the papers emphasised the *therapeutic relationship* as a means of '*instilling*' or '*uncovering*' hope. Five papers presented the *therapeutic relationship* as a '*core*' or over-arching category (Cutcliffe, 2004; 2006a; Koehn & Cutcliffe, 2012; Larsen & Stege, 2010a; McCann, 2002; Yohani, 2010).

There was some variation in how the *therapeutic relationship* was seen to influence the process of developing hope. Some participants saw the *therapeutic relationship* as the context or environment in which the client could experience or "*bathe in*" hope (e.g. Cutcliffe & Grant, 2001; Ward & Wampler, 2010; Yohani, 2012). Other participants viewed the *therapeutic relationship* as the first step, or '*phase*' in a process of working to instil hope with the person (Cutcliffe, 2004; Koehn & Cutcliffe, 2006); or as an initial '*pre-step*' before the real hope-focussed work could begin (McCann, 2002). For others, the development of rapport and a strong therapeutic alliance was seen as the hope-inspiring intervention in itself (Kirkpatrick et al., 1995).

**Developing social links and connections.** Re-connecting with previous relationships and valued activities was seen as hope inspiring (Koehn & Cutcliffe, 2012; McCann, 2002). Developing connections to '*role models*', e.g. an individual who had recovered from similar mental health difficulties (Kirkpatrick et al., 1995; McCann, 2002) and developing links to the local community (Kirkpatrick et al., 1995; McCann, 2002; O'Hara & O'Hara, 2012; Yohani, 2010) were also identified as hope-promoting practices.

**Information sharing.** Practitioners gave examples of *sharing information* and *psycho-education* in order to develop service users' insight and understanding of their own mental health difficulties. For example practitioners provided information about a particular diagnosis or about the process of recovery (Cutcliffe, 2006b; Kirkpatrick et al., 1995; Koehn & Cutcliffe, 2012; O'Hara & O'Hara, 2012). In one study, this extended to educating other professionals and the wider community (Kirkpatrick et al., 1995). Participants in another study described sharing their understanding of hope with service users (Larsen & Stege, 2010b). However all participants in this study had a personal interest and had undertaken further study into hope. It was acknowledged that this strategy might not be transferable to other mental health practitioners.

**Developing different perspectives.** Participants across several papers discussed ways in which they worked collaboratively to help the client develop a *different perspective* of themselves and of their future. Koehn and Cutcliffe (2012) suggested that '*enhancing possibilities of a changed future*' was the key means through which practitioners developed hope with their clients.

Practices to develop *different perspectives* included '*re-framing*' difficulties as opportunities or a chance for personal growth (Cutcliffe, 2004; 2006b; Larsen & Stege, 2010a; O'Hara & O'Hara, 2012; Ward & Wampler, 2010); for example helping a client to see a relapse as an opportunity to learn rather than as a failure (Koehn & Cutcliffe, 2010). Themes also

emerged around providing opportunities for clients to '*experience success*' (Darlington & Bland, 1999; Koehn & Cutcliffe, 2010; Yohani, 2012). Practitioners fostered hope by helping clients to identify '*exceptions*' or times when they had overcome past difficulties and to draw on these strengths (Larsen & Stege, 2010a; Ward & Wampler, 2010). Participants in Ward and Wampler (2010) described the chance to take a more objective perspective and normalise service users' difficulties as powerful hope-instilling strategies.

**Uncovering values and goals.** Practitioners developed hope by helping service users to identify their personal *values* and strengths (McCann, 2002; Yohani, 2012). They also helped service users to set *goals* based on personal values and ideals and to work towards their *goals* (Darlington & Bland, 1999; Koehn & Cutcliffe, 2012; Larsen & Stege, 2010b; McCann, 2002; Kirkpatrick et al., 1995). *Goals* were seen as an important means through which to build hope by helping clients to uncover a sense of meaning in their lives, increase motivation for recovery and develop self-esteem.

### **Challenges to Hope**

Six papers explicitly discussed difficulties in fostering hope within clients (Kirkpatrick et al., 1995; Koehn & Cutcliffe, 2012; Larsen & Stege, 2010b; McCann, 2002; O'Hara & O'Hara, 2012; Yohani, 2012). These difficulties were captured under the third analytical theme, *challenges to hope*, which comprised three descriptive themes.

**Client challenges.** O'Hara & O'Hara (2012) identified several '*internal blockages*' to hope, or blocks experienced by the clients themselves. These included the client having a history of abuse or trauma, or experiencing grief. In contrast, bereavement counsellors in the study by Cutcliffe (2004; 2006a, 2006b) described how they worked to instil hope with individuals experiencing grief and loss.

Participants across several papers identified that the severity or unpredictability of a service user's mental health difficulties could make it

difficult to help foster a sense of hope (Kirkpatrick et al., 1995; McCann, 2002; O'Hara and O'Hara, 2012). One participant in O'Hara and O'Hara (2012) identified that mental health difficulties could lead a client to perceive their life as "*meaningless*", which was seen as an internal block.

**Clinician challenges.** A number of practitioners emphasised the need for support to maintain their own sense of hopefulness (Cutcliffe, 2004; McCann, 2002; Kirkpatrick et al., 1995; Yohani, 2010). Usually this was in the form of supervision although other forms of support such as accessing "*personal therapy*" (Cutcliffe, 2004) were also noted.

Practitioners discussed the importance of remaining "*genuinely hopeful*" (Cutcliffe & Grant, 2001; Darlington & Bland, 1999; Larsen & Stege, 2010a; Ward & Wampler, 2010) in order to maintain the "*credibility*" (Koehn & Cutcliffe, 2012) to inspire hope within service users. However, some participants described how hopelessness arose as a result of not feeling skilled to manage the client's difficulties or their own emotional response (Yohani, 2012). Maintaining a sense of personal hopefulness and fostering hope with service users could be '*challenging*' (Kirkpatrick et al., 1995; McCann, 2002; O'Hara & O'Hara, 2012). Furthermore clinicians identified that not feeling connected to the service user and difficulties in developing the therapeutic relationship had an impact on their perceived ability to foster hope with the person (Cutcliffe & Grant, 2001; Kirkpatrick et al., 1995; McCann, 2002; O'Hara & O'Hara, 2012).

Whilst practitioners needed to remain hopeful, they were also mindful of remaining open to hearing and acknowledging the client's despair or hopelessness (Cutcliffe, 2006a; Kirkpatrick et al., 1995; Larsen & Stege, 2010a). Witnessing despair was seen as the "*flipside*" or "*dialectic*" to hope and was necessary in order to help develop hopefulness (O'Hara & O'Hara, 2012; Yohani, 2010). Participants working with individuals who had received a diagnosis of schizophrenia highlighted that having "*too much*" or unrealistic hope could lead to them "*not hearing*" the client, which negatively impacted on hope (Kirkpatrick et al., 1995).



**Systemic challenges.** O'Hara & O'Hara (2012) identified 'external' blockages to hope including the client's socio-economic circumstances, over which the client may have little direct control. Participants identified that a lack of access to resources such as education or social services could limit hope (also McCann, 2002).

Across several papers, themes emerged related to the on-going societal stigma associated with mental health difficulties (McCann, 2002; Kirkpatrick et al., 1995; Yohani, 2010). Practitioners in one study (Yohani, 2010) described that a lack of societal understanding of issues experienced by clients (e.g. loss and trauma) along with the clients' experience of racism and prejudice, were significant blocks to developing and maintaining a sense of hope.

### **Methodological Critique**

Articles were critically reviewed with respect to issues including credibility, reflexivity, ethics, coherence, resonance and value of the research. This allowed for consideration of the overall quality and rigour of the papers.

All but two of the papers (Darlington & Bland, 1999; Kirkpatrick et al., 1995) gave a clear description of the chosen methodology, the rationale behind this choice and a clear description of the data analysis process. Six studies provided information regarding checking methods, thereby enhancing the trustworthiness of the findings and methodological rigour. Methods included respondent validation, triangulation with data from other sources and use of external reviewers (Cutcliffe, 2004; 2006a, 2006b; Koehn & Cutcliffe, 2012; Larsen & Stege, 2010a, 2010b; O'Hara & O'Hara, 2012; Ward & Wampler, 2010; Yohani, 2010).

All studies included participant quotes, which illustrated categories and sub-themes well. Yohani (2012) drew on the extended metaphor of staff as '*hope gardeners*', nurturing the '*seed*' of hope, which provided a sense of coherence to the presentation of the findings. Of the six studies utilising GT

methodology, only three (Cutcliffe, 2004, 2006a, 2006b; Cutcliffe & Grant, 2001; Koehn & Cutcliffe, 2012) presented models that moved away from a description of what participants did to foster hope to a more analytical account. The analytical analysis is the hallmark of GT methodology (Birks & Mills, 2011). Only four of the GT studies provided sufficient detail regarding theoretical saturation to establish rigour (Koehn & Cutcliffe, 2012; O'Hara & O'Hara, 2012; Ward & Wampler, 2010).

Overall there was little evidence of reflexivity across the papers. Only half of the studies (Cutcliffe, 2004; O'Hara & O'Hara, 2012; Koehn & Cutcliffe, 2012; Larsen & Stege, 2010; Ward & Wampler, 2010) provided details of the authors' theoretical orientations and personal expectations. Detail, where present, was limited. It was therefore difficult to assess the authors' interpretation of the data and consider possible alternatives (Elliott et al., 1999).

## **Discussion**

This review has examined research that describes how practitioners working in mental health settings think about hope and how they work to instil hope with service users. A total of 10 studies were included within the review (see Table 1). Analysis revealed three broad themes within the research: *Beliefs about hope*, *facilitating hope* and *challenges to hope*. These themes are discussed in relation to existing research and the implications for clinical practice.

### **Beliefs about Hope**

A number of papers included definitions of hope as a *multi-dimensional* construct, which reflects theory and previous findings in this area (e.g. Dufault & Martocchio, 1985; Schrank et al., 2008). The cognitive aspect was evident in the conceptualisation of hope as largely focussed on the future, working towards positive goals and outcomes. These findings connect to Snyder's (2000, 2002) hope theory as staff found it important to attend to the pathways through which they can work with clients towards desired goals and outcomes (e.g. McCann, 2002). They also reflect

research with service users. For example in their review, Schrank et al. (2008) found hope was a primarily future-oriented expectation with goal-setting an important aspect.

There was some variation however. O'Hara and O'Hara (2012) and Cutcliffe (2004; 2006a, 2006b) made reference to hope as an acceptance of current life circumstances. Furthermore, some papers conceptualised hope less in terms of its' functions or qualities but more in terms of its' essential human nature (Cutcliffe & Koehn, 2012; Darlington & Bland, 1999). These conceptualisations may tap into the unique and intangible qualities of hope posited by Nekolaichuk et al. (1999). They also connect to views offered by researchers such as Vaillot (1974). Vaillot, writing about the experience of supporting cancer patients in their end of life care, emphasised that hope was not focussed on the future (e.g. recovery of a particular body function or hope for a cure) but was about helping the person to simply 'be' again. Vaillot suggested that the role of the clinician was to enable the person to '*reach out for a plenitude of being that is always possible*' (p. 272; in Elliott, 2005). In this review, participants saw their role as helping to foster the service user's own sense of hope in the context of an inter-personal relationship. This position was illustrated through the use of metaphors such as "*nurturing*" the "*seeds*" or "*sparks*" of the client's hope (Kirkpatrick et al. 1995; Yohani, 2010).

Having hope was generally seen as a positive experience, and some participants acknowledged that focussing on hope in their work with clients was a chance to move away from more problem-saturated talk (Larsen & Stege, 2010b). These findings suggest a role for the use of solution-focussed therapeutic approaches (e.g. de Shazer et al., 1986). Michael, Taylor and Cheavens (2000) suggest that these approaches foster hope by drawing on the client's strengths and skills, prioritising movement towards goals and change over exploration of problems.

Several papers noted that hope must be achievable (Darlington & Bland, 1999; Koehn & Cutcliffe, 2012; Ward & Wampler, 2010; Yohani, 2010)

and in some cases, a need for hopes to be realistic was endorsed (Darlington & Bland, 1999; Koehn & Cutcliffe, 2012; McCann, 2002). Within the broader health field, there is on-going discussion regarding the ethics of developing '*realistic*' hopes with clients (e.g. Larsen, Stege, Edey & Ewasiw, 2014; Simpson, 2004). Negotiating different perspectives of realistic hope was described as a '*delicate process*' (Koehn & Cutcliffe, 2012). Larsen et al. (2014) suggest that practitioners can overcome these difficulties through acknowledging the existence of multiple hopes and by recognising hope as a process that unfolds and is refined throughout the relationship. Several reviewed papers described hope as a process with different '*phases*' (Cutcliffe, 2004; 2006a, 2006b; Koehn & Cutcliffe, 2012) or '*levels*' (Ward & Wampler, 2010). Larsen et al. (2014) suggest that viewing hope as an evolving process (rather than a dichotomy of '*present*' or '*absent*') may also help practitioners resist the pressure to pathologise low hope.

Interestingly, only three papers discussed spirituality as a *source* of hope (Koehn & Cutcliffe, 2012; O'Hara & O'Hara, 2013; Ward & Wampler, 2010). This is in contrast to studies with service users and their families, who identify their religious and spiritual beliefs as an important source of hope (e.g. Bland & Darlington, 2002; Schrank et al., 2008; Vass, 2011). Previous research suggests that religion and spirituality are often absent from clinical training and practice (James & Wells, 2003; Walker, Gorsuch & Tan, 2004). One meta-analysis found that therapists had concerns about the ethics of discussing a client's religious beliefs in therapy (Carlson, Kirkpatrick, Hecker & Killmer, 2002). Such factors may contribute to the potential for mental healthcare staff to overlook a client's spiritual beliefs as a source of hope.

### **Facilitating Hope**

There were some overlaps between participants' *beliefs about hope* and the practices to *facilitate hope* across several papers. However, the studies included did not address these links specifically (O'Hara & O'Hara, 2012).

Hope was fostered by providing information to help service users' develop an understanding of psychological difficulties and encourage an active role in their own care (Cutcliffe, 2006b; Kirkpatrick et al., 1995; Koehn & Cutcliffe, 2012; O'Hara & O'Hara, 2012). Other means of *facilitating hope* included cognitive strategies, e.g. helping clients to develop different perspectives of themselves and their futures, uncovering values and setting goals (Cutcliffe, 2004; 2006b; Darlington & Bland, 1999; Kirkpatrick et al., 1995; Koehn & Cutcliffe, 2012; Larsen & Stege, 2010a, 2010b; McCann, 2002; O'Hara & O'Hara, 2012; Ward & Wampler, 2010). Practitioners also *facilitated hope* by helping service users to develop or maintain personal relationships (Larsen & Stege, 2010b; O'Hara & O'Hara, 2012; Ward & Wampler, 2010; Yohani, 2010), develop links to the local community and meet with other people who had been through similar experiences (Kirkpatrick et al., 1995; McCann, 2002; Yohani, 2010). The latter may inspire hope by acting as '*role models*' for recovery (e.g. Hobbs & Baker, 2012). These practices reflect the principles of the recovery model by developing individual agency, promoting social inclusion and the development of a meaningful personal identity (Roberts & Boardman, 2013).

In line with their *beliefs about hope* the current review found that practitioners, regardless of their professional background, viewed the development of the therapeutic relationship as the most important means through which to inspire hope. Studies with service users have similarly identified a trusting and understanding therapeutic relationship as important in the movement from despair to hope (Koehn & Cutcliffe, 2007; Cutcliffe & Koehn, 2007; Parkes & Freshwater, 2012; Schrank et al., 2012). In this review, participants highlighted a range of qualities and skills that helped them to develop a relationship with the client. These qualities, which included acceptance, empathy and being genuine (Cutcliffe & Grant, 2001; Darlington & Bland, 1999; Koehn & Cutcliffe, 2012; Larsen & Stege, 2010a; O'Hara & O'Hara, 2012; Ward & Wampler, 2010; Yohani, 2010) have clear links to the humanistic stance of Rogers (1957) and the '*core conditions*' of therapeutic change. The current findings reflect the proposal that hope is a

*'common factor'* in the therapeutic relationship, associated with psychological change, regardless of the approach utilised (Frank & Frank, 2004).

The development of hope in the context of the therapeutic relationship also connects to attachment and psychodynamic accounts of hope (e.g. Erikson, 1964/1994). In this review, clients were seen to internalise the practitioners' hope in a process of *'contagion'* (Kirkpatrick et al., 1995; Cutcliffe, 2004; 2006a, 2006b; Cutcliffe & Grant, 2001). Lemma (2004) suggested that hope could be thought of as the activation of an internalised relationship with a *'tolerant'* and *'reflective'* *'good object'*. The therapeutic relationship may be likened to the *'secure base'* (Bowlby, 1988) through which clients can begin to explore and develop a sense of hope. As the practitioner provides the secure base and has genuine aspirations for their client, it is not surprising that the therapist's level of hope has a significant influence on therapy outcomes, over and above that of the client's hope (Coppock, Owen, Zagarskas & Schmidt, 2010).

In order to develop hope, practitioners identified that there was also a need to *"really hear"* or appreciate a client's feelings of hopelessness (Kirkpatrick et al., 1995; Larsen & Stege, 2010a; O'Hara & O'Hara, 2012; Yohani, 2010). Practitioners in Kirkpatrick et al. (1995) highlighted that being completely open and accepting meant valuing and listening to the client's perspective even when it was one that they might not have wished. In doing so practitioners deepened their relationship with the individual and in some instances were able to draw on despair as an impetus for change (O'Hara & O'Hara, 2012).

### **Challenges to Hope**

The current review identified several *challenges* that practitioners experienced when inspiring hope in their clients. Maintaining a sense of personal hope was identified as the main challenge faced by the practitioners (Cutcliffe, 2004; McCann, 2002; Kirkpatrick et al., 1995; Yohani, 2010). Koehn and Cutcliffe (2012) describe a loss of clinician hope as a *'therapeutic tragedy'*. However participants acknowledged that the client's hope had an

impact on their own personal feelings of hopefulness (O'Hara & O'Hara, 2012), which was also perceived by clients themselves (Kirkpatrick et al., 1995). The current review also highlights that practitioners' hope may be influenced by wider systemic and societal factors, including on-going stigma associated with mental health difficulties (McCann, 2002; Kirkpatrick et al., 1995; Yohani, 2010).

In addition practitioners identified challenges that clients experienced. Client 'blocks' to hope included the unpredictability and severity of mental health or emotional difficulties and cognitive impairment, particularly when these were related to a background of trauma or abuse (Kirkpatrick et al., 1995; Cutcliffe & Grant, 2001; McCann, 2002; O'Hara & O'Hara, 2012). These factors were also seen as negatively impacting on a client's ability to develop the therapeutic relationship. It is important to note that all but two of the ten studies in the current review were conducted in community settings. Clients in inpatient or secure mental health services are more likely to experience complex or multiple mental health difficulties, have a history of trauma and abuse and also experience higher levels of social exclusion (e.g. Simpson & Penney, 2011). These factors may negatively impact on practitioners' perceptions of their ability to inspire hope in service users within such settings.

### **Clinical Implications**

This review highlights a number of similarities between service user and practitioner beliefs about hope and their views about what helps to foster hope. It may be beneficial to incorporate these views into hope-oriented training for mental healthcare staff. In particular, such training should emphasise the role of the therapeutic relationship in fostering hope. Hobbs and Baker (2012) suggest that there is a need for practitioners to remain continually aware of their ability to both foster and damage a client's sense of hope. It would also be beneficial for mental healthcare staff to receive further training about how to draw on a client's religious or spiritual beliefs as a source of hope.

The current review finds support for the use of cognitive and solution-focussed therapies to help foster client hope. In addition, attachment and psychodynamic theories may support practitioners in reflecting on the development of hope within the therapeutic relationship. Clinical psychologists are well placed to offer consultation or space for reflective practice that could draw on these models. However the review also indicates the need for further research to explore links between the practitioners' own sense of hopefulness, their beliefs about hope and the practices through which they work to instil hope with service users. Qualitative research may help to synthesise these factors into integrated theories (see also Cutcliffe & Koehn, 2007).

### **Limitations**

In order to enhance the quality of the papers included in the analysis, the current review included only those papers published in peer-reviewed, published journals. This may have discounted potentially relevant research or published literature (e.g. conference proceedings). More generally, it is highlighted that the same researchers conducted several studies included within the current review. This raises the potential for bias, particularly given the limited reflexivity evident across the papers reviewed.

The current review included only empirical papers that focussed predominantly on staff beliefs about hope and practices to instil hope. Studies focussed solely on staff experiences of personal hopefulness (Crain & Koehn, 2012; Flesaker & Larsen, 2010; Larsen, Stege & Flesaker, 2013) were excluded. Whilst such papers may have contributed to themes that emerged from the analysis, they were not in line with the original aims of the review. Potentially the inclusion of quantitative research may have broadened the scope and credibility of the review. Finally it is acknowledged that several papers included in the review were identified through hand searching of referenced papers and other relevant resources. Schrank et al. (2008) note similar difficulties in reliably reviewing the generic term 'hope' using scientific databases.



## **Conclusion**

Practitioners working in general mental health settings view hope as a multi-dimensional, positive concept and identify several practices through which they aim to develop hope in their clients. Some practices to facilitate hope, such as developing personal relationships and enhancing the service users' sense of agency and control, may be more difficult in certain mental health settings (e.g. secure or forensic units). Service users in such settings are also more likely to experience severe or unpredictable mental health difficulties, which may impact on the clinician's ability to develop a therapeutic relationship and their perception of their ability to foster hope. Further research would therefore benefit from exploring how staff in these settings work to facilitate hope. Further research should also aim to develop theories or frameworks that integrate staff beliefs about hope, the practices through which they work to instil hope and the ways in which they overcome 'blocks' to hope.

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## **Appendices**

### **Appendix**

- 1 Journal of Mental Health Guidelines for Authors
- 2 Checklist to assess quality and rigour in qualitative research

## Appendix 1 Journal of Mental Health Guidelines for Authors

The following information is taken from the journal's website.

### **Journal of Mental Health Instructions for Authors**

#### **Aims and Scope**

The Journal of Mental Health is an international forum for the latest research in the mental health field. Reaching over 65 countries, the journal reports on the best in evidence-based practice around the world and provides a channel of communication between the many disciplines involved in mental health research and practice.

The journal encourages multi-disciplinary research and welcomes contributions that have involved the users of mental health services.

The international editorial team is committed to seeking out excellent work from a range of sources and theoretical perspectives. The journal not only reflects current good practice but also aims to influence policy by reporting on innovations that challenge traditional ways of working. We are committed to publishing high-quality, thought-provoking work that will have a direct impact on service provision and clinical practice.

The Journal of Mental Health features original research papers on important developments in the treatment and care in the field of mental health. Theoretical papers, reviews and commentaries are also accepted if they contribute substantially to current knowledge.

#### **Submissions**

All submissions, including book reviews, should be made online at Journal of Mental Health's

Manuscript Central site at <http://mc.manuscriptcentral.com/cjmh>

New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre. Please note that submissions missing reviewer suggestions are likely to be un-submitted and authors asked to add this information before resubmitting. Authors will be asked to add this information in section 4 of the on-line submission process.

Manuscripts will be dealt with by the Executive Editor. It is essential that authors pay attention to the guidelines to avoid unnecessary delays in the evaluation process.

The names of authors should not be displayed on figures, tables or footnotes to facilitate blind reviewing.

#### **Word Count**

The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do not

include the abstract, tables and references in this word count. However manuscripts are limited to a maximum of 4 tables and 2 figures.

### **Manuscript Style**

Manuscripts should be typed double-spaced (including references), with margins of at least 2.5cm (1 inch). The cover page (uploaded separately from the main manuscript) should show the full title of the paper, a short title not exceeding 45 characters (to be used as a running title at the head of each page), the full names, the exact word length of the paper and affiliations of authors and the address where the work was carried out. The corresponding author should be identified, giving full postal address, telephone, fax number and email address if available. To expedite blind reviewing, no other pages in the manuscript should identify the authors. All pages should be numbered.

**Abstracts:** The first page of the main manuscript should also show the title, together with a structured abstract of no more than 200 words, using the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest.

**Acknowledgement** of individuals should be confined to those who contributed to the article's intellectual or technical content.

**Keywords:** Authors will be asked to submit key words with their article, one taken from the pick-list provided to specify subject of study, and at least one other of their own choice.

**Text:** Follow this order when typing manuscripts: Title, Authors, Affiliations, Abstract, Keywords, Main text, Appendix, References, Figures, Tables. Footnotes should be avoided where possible. The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do not include the abstract, tables and references in this word count. Language should be in the style of the APA (see Publication Manual of the American Psychological Association, Fifth Edition, 2001).

**Style and References:** Manuscripts should be carefully prepared using the aforementioned Publication Manual of the American Psychological Association, and all references listed must be mentioned in the text. Within the text references should be indicated by the author's name and year of publication in parentheses, e.g. (Hodgson, 1992) or (Grey & Mathews 2000), or if there are more than two authors (Wykes et al ., 1997). Where several references are quoted consecutively, or within a single year, the order should be alphabetical within the text, e.g. (Craig, 1999; Mawson, 1992; Parry & Watts, 1989; Rachman, 1998). If more than one paper from the same author(s) a year are listed, the date should be followed by (a), (b), etc., e.g. (Marks, 1991a).

The reference list should begin on a separate page, in alphabetical order by

author (showing the names of all authors), in the following standard forms, capitalisation and punctuation:

a) For journal articles (titles of journals should not be abbreviated):

Grey, S.J., Price, G. & Mathews, A. (2000). Reduction of anxiety during MR imaging: A controlled trial. *Magnetic Resonance Imaging*, 18, 351–355.

b) For books:

Powell, T.J. & Enright, S.J. (1990) *Anxiety and Stress management*. London: Routledge

c) For chapters within multi-authored books:

Hodgson, R.J. & Rollnick, S. (1989) More fun less stress: How to survive in research. In G.Parry & F. Watts (Eds.), *A Handbook of Skills and Methods in Mental Health Research* (pp. 75–89). London:Lawrence Erlbaum.

Illustrations: should not be inserted in the text. All photographs, graphs and diagrams should be referred to as 'Figures' and should be numbered consecutively in the text in Arabic numerals (e.g. Figure 3). The appropriate position of each illustration should be indicated in the text. A list of captions for the figures should be submitted on a separate page, or caption should be entered where prompted on submission, and should make interpretation possible without reference to the text. Captions should include keys to symbols. It would help ensure greater accuracy in the reproduction of figures if the values used to generate them were supplied.

Tables: should be typed on separate pages and their approximate position in the text should be indicated. Units should appear in parentheses in the column heading but not in the body of the table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should not be used.

## Appendix 2 Tool to assess quality & rigour in qualitative research

Adapted from the Critical Appraisal Skills Programme (CASP) Qualitative Checklist (Public Health Resource Unit, England, 2006) and guidelines for the publication of qualitative research studies in psychology and related fields (Elliott, Fischer & Rennie, 1999).

Author, date & paper title:

**Screening questions** (must answer 'yes' to both; if not, consider whether to discontinue)

1. Is there a clear statement of the research aims? ☐ Yes ☐ No

- What is the goal of the research?
- Why is it important?

2. Is a qualitative methodology appropriate? ☐ Yes ☐ No

- Does the research seek to interpret or illuminate the actions and/or subjective experiences of research participants?

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### **Appropriate research design**

3. Is the research design appropriate to address the aims of the research?

- Has the researcher justified the research design (e.g. have they discussed how they decided which methods to use?)

*Comments:*

### **Sampling and participants**

4. Was the recruitment strategy appropriate to the aims of the research?
  - Has the researcher explained how participants were selected?
  - Have they explained why the participants selected were most appropriate to provide access to the type of knowledge sought by the study?
  - Is there any discussion around recruitment (e.g. why some participants chose not to take part?)
  - Are any specific recruitment processes relevant to the method chosen outlined?
5. Have the researchers situated their sample? E.g. have they given sufficient background information to know who the participants are and brief details about their life circumstances, in order that the reader can judge the range of people and situations to who the findings may be relevant?

*Comments:*

### **Data collection**

6. Were the data collected in a way that addressed the research issue?
  - Is the setting for data collection justified?
  - Is it clear how data were collected (e.g. focus group, semi-structured interviews etc.)?
  - Has the researcher justified the methods chosen?
  - Has the researcher made the methods explicit? (e.g. for interview method is there an indication of how interviews were conducted, did they use a topic guide?)
  - If methods were modified during the study, has the researcher explained how and why?
  - Is the form of data clear? (e.g. tape recordings, video material, notes)
  - Has the researcher discussed saturation of the data?

*Comments:*

### **Reflexivity**

7. Has the relationship between researcher and participants been adequately considered?

- Does the researcher own their perspective? (E.g. have they specified their theoretical/personal orientations, both as known in advance and as they become apparent during the research?)
- Has the researcher made attempts to recognise the potential impact of their own values, interests and assumptions? (E.g. on the formulation of research questions; on data collection including sample recruitment and choice of location; on their understanding of the data, during analysis and selection of data for presentation)

*Comments:*

### **Ethical issues**

8. Have ethical issues been taken into consideration?

- Are there sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained?
- Has the researcher discussed any issues raised by the study? (e.g. around confidentiality or informed consent, or how they handled the effects of the study on the participants during and after the study)
- Has approval been sought from an appropriate ethics committee?

*Comments:*

## **Data analysis**

9. Was the data analysis sufficiently rigorous?

- Is there an in-depth description of the analysis process?
- Is it clear how categories/codes/themes were derived from the data?
- Are the analytic procedures and the understanding developed in light of them grounded in examples from the data (e.g. providing specific examples of themes or of the information used to generate categories)
- To what extent are contradictory data taken into account?

*Comments:*

## **Findings**

10. Is there a clear statement of the findings?

- Are the findings explicit?
- Are sufficient examples from the data presented in order that the reader can conceptualise possible alternative meanings and understandings?
- Has the researcher given examples of credibility checks? (e.g. triangulation, respondent validation, more than one analyst etc.)
- Are the findings discussed in relation to the original research question?

*Comments:*



### **Coherence**

11. Are the findings presented in such a way to achieve coherence?

- Does the understanding fit together to form a data driven story or narrative, 'map', framework or underlying structure for the phenomenon/domain?
- Has the nuance of the data been preserved? (e.g. through rich descriptions/categories, verbal narratives etc.)

*Comments:*

### **Resonance**

12. Does the research resonate with the reader?

- Is the material presented in a way that allows the reader to judge that it has accurately represented the subject matter, or clarified/expanded their understanding or appreciation of it?
- Have participants' experiences been 'brought to life' for the reader?

*Comments:*

### **Value of the research**

13. How valuable is the research?

- Does the researcher discuss the contribution the study makes to existing knowledge or understanding? (e.g. in relation to current practice, policy or relevant research-based literature?)
- Are the generalisability and limitations of the findings discussed?
- Do the researchers identify new areas where research is necessary?

*Comments:*

## **Paper 2**

### ***“Your personality is the intervention”*: A Grounded Theory of Mental Health Nurses’ Beliefs About Hope and Experiences of Fostering Service Users’ Hope Within a Secure Setting**

This paper has been written broadly in line with the guidelines for the Journal of Forensic Psychiatry and Psychology (please see Appendix 1 & 2 for full guidelines)

**Word count:** 8, 293 (exclusive of abstract, tables, figures and references)

### **Abstract**

Hope is widely regarded as an important factor in psychological resilience and change, and recovery from mental health difficulties. Recently there has been an increased focus on recovery-oriented practice within forensic mental health settings. Several policies include calls for mental health practitioners to inspire hope for recovery in the individuals they work with. However there is little suggestion of how to implement such recommendations in practice or research exploring how staff foster hope in forensic settings. This qualitative study utilised a Grounded Theory (GT) approach to explore nurses' perspectives and experiences of hope within a medium secure setting. The use of GT methodology allowed for the development of a model that integrated nurses' beliefs about hope, practices to develop hope with service users and the emotional impact of this work. The nurses' values played a significant role in their work to develop hope. Recommendations are made to help manage the emotional impact and address challenges unique to fostering hope within the forensic setting.

**Keywords:** Hope, nurse, secure, mental health, beliefs

## Background

### Hope and Mental Health

Hope is widely recognised as an important factor within the field of mental health (see reviews by Cutcliffe & Koehn, 2007; Koehn & Cutcliffe, 2007; Kylmä et al., 2006; Schrank, Stanghellini & Slade, 2008; Schrank, Bird, Rudnick & Slade, 2012). A number of definitions and conceptualisations have emerged across the literature, highlighting the cognitive (e.g. Snyder, 1995, 2002) or affective (e.g. Lazarus, 1999) aspects of hope. Others (e.g. Dufault & Martocchio, 1985) have proposed that hope is a multi-dimensional construct. For example, Schrank et al. (2008, p.426) defined hope as *‘a primarily future oriented expectation ... of attaining personally valued goals which will give meaning, are subjectively considered possible and depend on personal activity or characteristics ... and/or external factors’*. Schrank, Hayward, Stanghellini and Davidson (2011) summarised that hope is important to psychological resilience and well-being (Magaletta & Oliver, 1999; Ong, Edwards & Bergeman, 2006) and is consistently identified as a *‘common factor’* contributing to change and gains in psychotherapy (Duncan, Miller, Wampold & Hubble, 2010; Hayes et al., 2007).

Hope has also been identified as an essential component in the recovery model (Bonney & Stickley, 2008; Marino, 2015; Shepherd, Boardman & Slade, 2008). Anthony (1993, p.14) defined recovery as *‘a deeply personal process, with a focus on developing new meaning and purpose in one’s life in order to grow beyond the impact of mental illness’*. In the latter half of the last decade several key policy documents emphasised the need to develop recovery-oriented mental health services in the United Kingdom (e.g. Department of Health, DoH, 2001 & 2009; National Institute for Mental Health in England, NIMHE, 2005; Shepherd et al., 2008). Recovery-oriented services move away from the traditional approach of ‘treating’ mental health ‘symptoms’ and are guided instead by principles including promoting wellness, strength and health; hope and personal agency; and social inclusion (Repper & Perkins, 2003; Roberts & Boardman, 2013). Warner (2010) cites support for recovery-oriented principles in improving functioning and quality of life following mental health difficulties.

## **Practitioner Views of Hope**

Several recovery-oriented policy documents include calls for mental health care staff to develop hope in their relationships with service users (e.g. Maddock & Hallam, 2010; NIMHE, 2005; Repper & Perkins, 2003: South London and Maudsley NHS Foundation Trust/South West London and St George's Mental Health NHS Trust, SLAM/SWLSTG, 2010). Guidance to help clinicians implement such recommendations within their clinical practice is lacking (Hobbs & Baker, 2012).

A small number of studies have explored mental health practitioners' beliefs about hope and the practices they employ with the aim of inspiring hope in service users (see Paper 1 for a comprehensive review and synthesis of these studies). The therapeutic relationship emerged as an important means through which to develop hope (e.g. Cutcliffe, 2004; 2006; Koehn & Cutcliffe, 2012; Larsen & Stege, 2010; McCann, 2002; Yohani, 2010). Practitioners identified that being '*genuinely*' hopeful and maintaining their own sense of hope was also vital to foster a sense of hope in their clients (Cutcliffe, 2004; Cutcliffe & Grant, 2001; Darlington & Bland, 1999; Kirkpatrick et al., 1995; Larsen & Stege, 2010; McCann, 2002; O'Hara & O'Hara, 2012; Ward & Wampler, 2010; Yohani, 2010). A small number of studies have explored the lived experience of hope amongst psychologists (Larsen, Stege & Flesaker, 2013) and support workers in mental health settings (Crain & Koehn, 2012; Flesaker & Larsen, 2010). Larsen et al. (2013) stated that mental health practitioners need to attend to their own level of hope, particularly as practitioner hope has been found to influence psychotherapeutic outcome over and above client hope (Coppock, Owen, Zagarskas & Schmidt, 2010). Thus far, research has had little to say about the interaction between practitioners' beliefs about hope, personal hopefulness and practices to inspire hope. Spandler and Stickley (2011) called for a greater understanding of the interpersonal practices and contexts that allow compassionate, hope-focussed care to flourish.

Previous research has focussed solely on practitioners within community or general mental health settings. Although specialist services

have been slower to adopt the principles of recovery-oriented care in comparison to mainstream mental health settings (Turton et al., 2011) over recent years there has been an increased focus on the recovery approach within forensic mental health settings (e.g. Drennan & Alred, 2012; Simpson & Penney, 2011).

### **Hope and Forensic Mental Health**

Hope and recovery are particularly relevant within forensic services given the additional and unique rehabilitative needs often present for clients in such settings (Simpson & Penney, 2011; SLAM/SWLSTG, 2010). Corlett and Miles (2012) found that both service users and practitioners in a secure service viewed hope as the most important factor for recovery. Furthermore hope has been associated with a lower risk of future violence (Martin & Stermac, 2009). Hope may act as a protective factor by enhancing an individual's engagement with therapeutic activity and fostering their belief in a more positive future (Hillbrand & Young, 2008; Martin & Stermac, 2009).

Hillbrand and Young (2008) pointed out that practitioners in forensic mental health settings are at particular risk of losing hope, given the high levels of distress and stigma often experienced by mental health service users who have also committed offences (see also Mezey et al., 2010). In a qualitative study exploring the views of service users within a medium secure mental health setting Vass (2011b) found that experiences of hope did not differ greatly from those of individuals within general mental health settings. However it was suggested that the perceived demand for compliance within this context could undermine service users' sense of hope and progress. Vass (2011b) called for research to examine how forensic mental healthcare staff work to foster hope, to explore how this fits with service user views and to understand any unique challenges present within the forensic setting.

### **Aim**

The current study initially aimed to address an identified gap in the literature by exploring the following research questions: *What are forensic mental health nurses' beliefs about hope and how do they aim to foster hope*

*with service users?* Qualified nurses were selected as an appropriate sample given their high level of contact with service users and their responsibility for implementing individual care plans.

During data collection and analysis many participants spoke of their emotional response to developing hope with service users and the personal and professional impact of this work. The research question was therefore modified to: *What are mental health nurses' beliefs about hope and their experiences of fostering hope with service users in a forensic mental health setting?* Grounded Theory (GT) was selected as an appropriate methodology, given the previous lack of research into the specific area. Cutcliffe and Koehn (2007) pointed out that GT is well-suited for developing a formal theory of the psychosocial processes of hope inspiration.

## **Method**

### **Participants**

A sample of ten qualified mental health nurses (five men and five women) took part in the study. Qualified nurses were selected as an appropriate sample given their high level of contact with service users and their responsibility for implementing individual care plans. Participants were aged between 32 and 57 years (mean age = 40.7 years) and had been employed in their current role between three months and 18 years (mean time in role = 7.5 years). All participants identified their ethnicity as White British.

### **Procedure**

The research took place at a male medium secure NHS hospital in England. In line with GT methodology, initial purposive sampling of mental health nurses ensured that the emerging grounded theory was based on rich data from participants who had all experienced the processes and interactions of interest (Charmaz, 2014; Priest & Tweed, 2015). The clinical research supervisor and researcher provided a copy of the Participant Information Sheet (PIS; see Appendix 6) to qualified nurses they believed may be interested in the study. Information about the study was also entered

into the communication diary used by all members of nursing staff on each ward at the research site. A total of 20 nurses were provided with a copy of the information sheet and 10 agreed to take part in the study. As data analysis progressed, theoretical sampling was utilised to consider who could best provide information-rich data in order to better define the emerging themes and categories (Birks & Mills, 2011). For example, following the analysis of eight transcripts a need to consider the impact of summative nursing experience on beliefs and practices to foster hope was identified. Therefore, the ninth interview was conducted with a recently qualified nurse.

Semi-structured interviews were conducted in a quiet office location. Brief demographic details were obtained at the outset of the interview (see Appendix 8). Interviews lasted between 33 and 65 minutes (average length of interview = 48 minutes). Each interview was audio-recorded and transcribed by the researcher. All potentially identifiable information was removed or altered during transcription to protect participant anonymity.

### **Ethical Considerations**

Ethical approval was granted following scrutiny by both an independent university ethics committee and the research and development department of the NHS Trust in which the study was carried out (see Appendices 3 and 4).

The research was conducted in accordance with published ethical guidelines (British Psychological Society; BPS, 2010). All participants were asked to sign a consent form (see Appendix 7) and were informed of the procedure to withdraw their data up until publication of the findings. Whilst it was not expected that the nature of the research interview would cause participants emotional distress, a procedure to manage any concerns was outlined within the information sheet, including access to a clinical psychologist based at the research site. Two participants took the offered opportunity to read a copy of their interview transcript, which resolved the concerns that one participant had regarding anonymity.



## **Analytic Strategy**

Hobfoll, Briggs-Phillips and Stines (2003) pointed out that the influence of social context on hope is important and often overlooked in the many theoretical models and descriptions of hope. This study employed a social constructionist GT approach (following the method of Charmaz, 2014) in order to acknowledge the existence of multiple realities and meanings of hope constructed through social interaction.

The initial interview schedule was broad and open in order to capture issues important to participants, and the personal meanings and interpretations of their experiences. Questions included, *Could you tell me what the word hope means to you? What helps you to instil or maintain hope with the service users you work with?* The initial schedule was developed through consideration of interview questions used in other relevant research (e.g. Cutcliffe & Grant, 2001; Crain & Koehn, 2012) and in conjunction with a member of the research team experienced in the use of GT methodology (See Appendix 9 for full initial interview schedule).

Initial codes were constructed across the first five transcripts. Initial coding remained close to the data by breaking it down into short, meaningful segments (as suggested by Rennie, Phillips & Quartaro, 1988). In particular the purpose of initial coding was to identify actions within the data. Words to code were therefore selected that reflected actions, and at times 'in vivo' or verbatim quotes from participants were utilised (Charmaz, 2014). Following initial coding, focussed coding was conducted to identify common themes and codes with greatest analytical 'power' to form the basis of tentative categories (Charmaz, 2014) (see Appendix 12 for a coding example, and Appendices 15 and 16 for examples of focussed coding). The purpose of focussed coding was to develop individual categories more fully by connecting sub-categories, and fully developing the range of properties and their dimensions, and through linking categories together (Birks & Mills, 2011). Birks and Mills (2011) summarise that initial coding is utilised to fracture the data, whilst focussed coding aims to reconnect the data in a much more conceptually abstract way.

Data were analysed utilising the constant comparative technique, meaning that initial and focussed coding were conducted alongside each other. Initially data were compared with data, progressing to comparisons between interpretations translated into codes and categories. Codes and categories were compared with original data and new data as they were acquired (Mills, Bonner & Francis, 2006). Memos were written throughout this process in order to explicate similarities and themes across the data, identify gaps in understanding and to speculate on potential emerging categories (see Appendices 13 and 14 for examples). The interview schedule was adapted to further develop emerging categories (see Appendices 10 and 11 for examples of adapted interview schedules).

Focussed codes were initially clustered into 32 groups (see Appendix 17). Further sorting and memo writing collapsed these groups into seven categories comprising 29 sub-themes (see Appendix 19). Theoretical sorting and refining of categories continued until a model was developed that was judged to best fit the data. This model comprised one overarching category and three main categories, each comprising several sub-themes and moderating factors (see Table 1). Whilst the limited time available to collect data meant that it was unlikely that theoretical saturation was achieved, categories were constructed in order that each category contained sufficient data. All participants contributed to the overarching category.

### **Rigour and Reflexivity**

A social constructionist epistemology meant that the researcher examined rather than erased how their privileges and preconceptions may have shaped the analysis (Charmaz, 2014). The researcher questioned and examined the influence of their prior experiences of working within forensic mental health services and their beliefs about hope and the recovery model, through the process of memo writing and keeping a reflective journal. A tenth interview was arranged in order to test out categories (of *doing hope* and *being the intervention*; see Appendix 11) and to further explore the category of *having an emotional impact*. Emerging categories were discussed with the research supervisors and during supervision groups with fellow

colleagues utilising GT methodology (see Appendix 18 for an example of an initial framework) in order to ensure transparency and coherence. The researcher's position within the research and methodological critique of the study are explored fully elsewhere (see Paper 3).

## Findings

A main theme of *holding on to hope* was constructed from the data analysis. This category reflected the *value* that the nurses placed in hope, both personally and professionally. Inspiring hope was seen as an integral part of the nursing role. *Holding on to hope* captured the *genuine* and *unconditional hope* the nurses strove to maintain for the people they worked with. It was seen as an over-arching category as it represented the context in which all other nurse - service user interactions took place.

Two categories captured the practices through which nurses aimed to foster hope with service users: *being the intervention* and *doing reasonable hope*. These two categories were inter-linked, with practices in one area influencing the other. Three sub-themes emerged that integrated and modified the way in which the nurses moved between the two categories: their *beliefs about hope*, conceptualising *hope as a journey* and the *restricted environment* of the secure unit. Whilst seen as essential, fostering hope was also seen as difficult or challenging work. The category *emotional impact* reflected the variety of emotional responses evident in the data and the way in which the nurses managed these reactions. A theme labelled the *reciprocal relationship of hope* reflected the way in which the nurses' sense of hope influenced the service users' hope and vice versa; it also captured the parallels between practices through which nurses worked to develop hope with service users and the practices through which they maintained and nurtured their own sense of hope.

Together these categories and processes represent one interpretation of forensic mental health nurses' experience of fostering hope. The categories and themes are outlined in Table 1, together with a visual framework that illustrates the links between them (see Figure 1).

Table 1 Categories and contributing codes

<b>Level of analysis</b>	<b>Contributing themes (grouped focussed codes)</b>
<b>Over-arching category</b>	
<b>Holding on to hope</b>	Holding on to hope Persevering to develop hope Having genuine hope Unconditional positive hope Personal values/professional role
<b>Categories</b>	
<b>Being the intervention</b>	Being the intervention Building a therapeutic relationship Attuning to the person Getting to know the whole person Breaking down the divide
<b>Doing reasonable hope</b>	Setting goals Focus on progress Empowering the person: responsibility, choice, control Developing a positive story Developing a different imagined future Reasonable hope
<b>Emotional impact</b>	Having an emotional impact Negotiating the emotional impact Team dynamics Reciprocal relationship of hope
<b>Moderating factors</b>	
<b>Beliefs about hope</b>	Future oriented Hope as motivating The individual in their context Having goals to work towards Believing/anticipating positive change Hope as a feeling Hope as universal/essential Hope as elusive
<b>The restricted environment</b>	Managing uncertainties Becoming disempowered: service user losing autonomy Imposed hopes: meeting targets Stigmatising risk Negotiating a dual role
<b>Journeying with the person</b>	Journey of hope reflecting journey through the unit Journeying with the person through the system Seeing the whole picture Reflecting back and looking forwards, together

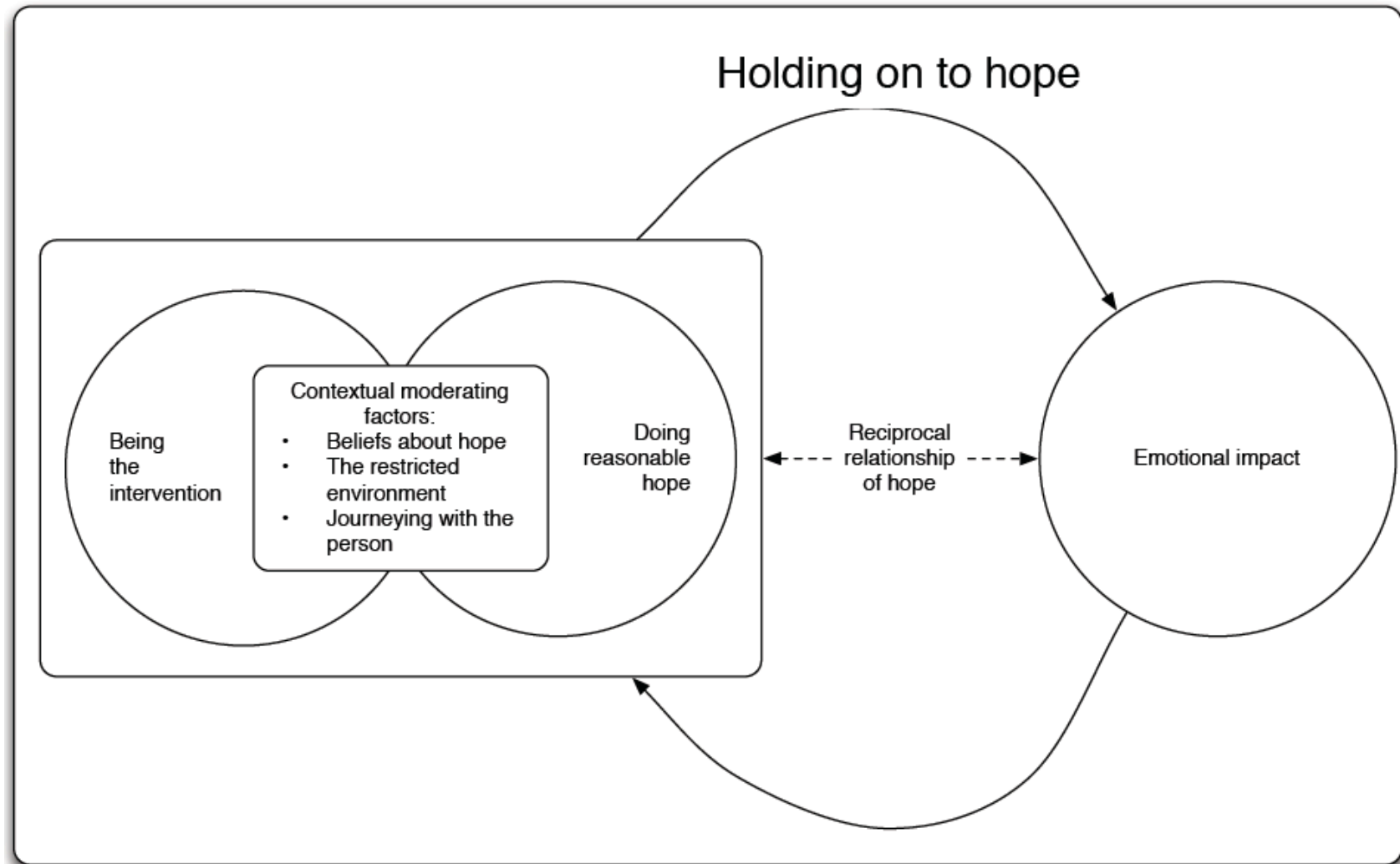


Figure 1 Model of nurse experience of hope

The theme *beliefs about hope* will be outlined initially, to provide a context for the use of the term throughout the rest of the model. The overarching category is then described in further detail followed by the other main categories.

### **Beliefs about Hope**

Participants in the study were asked what the term 'hope' meant to them. It was acknowledged that hope is a unique phenomenon. For example, one participant stated: *"For each individual it's different isn't it and for the guys in here ... it's a different hope isn't it really than my kind of hope"* (participant 3, L 9-12). The content of what one hoped for was therefore seen as influenced by the person's context. A number of participants commented specifically on the difficulty of defining hope or *"putting it into words"* (participant 2).

However, a definition of hope that captured the nurses' beliefs is summarised as: Hope is a highly individual phenomenon and is a belief in or anticipation of positive future change. The affective and cognitive elements of hope influence behaviour, through motivating or energising the individual to work towards desired goals and outcomes.

### **Holding on to Hope**

This overarching category was based on the nurses' outlook and attitude towards hope, which was largely driven by their *values*.

Eight participants discussed hope or *"being hopeful"* (participant 4) as a *personal value*. All of the nurses suggested that fostering hope was also an *"essential"* or *"core"* (participants 3, 9) aspect of the professional nursing role. The eight nurses who spoke most passionately about fostering hope with service users were those for whom hope was bound up in both their personal and professional identity. For example, participant eight stated: *"Nursing isn't a job, it's a way of life, you know what I mean?"* (L 316-317) whilst participant six reflected on how they had learnt to inspire hope in others: *"I think quite a lot of it is on who you are as a person, so there's a lot*

*of your values and beliefs”* (L 471-472)

Their *values* underpinned the nurses’ *“genuine hope”* and belief in the clients’ capacity for positive change, which was emphasised by seven participants. The nurses viewed this position (labelled by participant eight as *“buying what you are selling”*) far more favourably than the alternative, which was to express hope but not really believe in it (participant two described this as *“going through the motions”*). The latter position was seen as neither credible nor effective: *“[service users] can see if you don’t actually believe that”* (participant 5, L 51-52).

The nurses’ values also underpinned the concept of hope as universal and *unconditional*. Participants held on to *genuine hope* and worked to develop it with all service users in all situations, even at times when they had doubts: for example, participant five spoke of *“being a role model”* and *“believing that things can improve [for the client]”* even in situations *“when the evidence isn’t that helpful”* (L 53-57). As a result, the nurses spoke of *persevering to develop hope* with service users when they felt *“disheartened”* or that they *“weren’t getting anywhere”* (participant 4). Participant four summarised this view: *“You just have to keep going! Don’t you. You just have to keep trying ... whilst he’s here we have to work with him, and we have to do our best”* (L 336-339). Continually working to develop hope was therefore seen as a *“daily”* (participant 9), evolving process.

### **Being the Intervention**

The nurses’ personalities and behaviours were seen as hope-inspiring interventions in themselves: *“our personality is the intervention, you’re the medicine”* (participant 5, L 247-248) whilst participant ten stated, *“yourself is the sharpened tool that you can bring”* (L 732-733).

Nurses demonstrated hope through their demeanour and interactions with other people for instance by *“just carrying a positivity around with you”* (participant 7, L 264-265). Demonstrating *“cheerfulness”* through *“body language, face, openness”* was seen as a *“good start”* (participant 5, L 103-

105). Participant two described being “*enthusiastic*” about the life of the person they worked with, which would eventually “*infect*” the person with hope and positivity.

Such an approach was seen in the context of “*building the relationship with patients*” (participant 5, L 252). In order to develop the relationship, nurses identified the importance of “*spending time*” (participant 8), *getting to know the whole person* and “*treating patients as people*” (participant 6), rather than seeing just their mental health diagnosis (“*that’s secondary, that’s not who they are...*” participant 10, L 181-182). Several nurses spoke of the need to maintain a non-judgemental approach, particularly in reference to the person’s offending history. Participant five stressed how important it was to “*try very hard*” not to make judgements about service users. Others discussed that it was impossible to avoid forming judgements about a person’s behaviour. However, they worked hard to appear non-judgemental: “*Obviously people do judge, because we have to judge, to a certain degree to make decisions, but your patients don’t know ... and it’s the same with hope*” (participant 4, L 286-291)

Nurses adapted and tailored their approach to fostering hope based on the person they worked with. This process could be seen as *attuning* or being sensitive to the individual’s needs: “*It depends on the client, I have to know who I’m talking to enough to know how to BE with them*” (participant 7, L 304-305). It was important to relate to the individual and foster a sense of hope in a meaningful way. Participant eight referred to “*keeping it real*” with people whilst participant six explained that asking a service user directly “*what does hope mean to you?*” sounded “*cheesy*” and risked “*push[ing] people away*” (L 515-520). How the nurses worked to develop hope was also influenced by the service users’ readiness to change or “*hear*” (participant 4) what they had to say. Nurses were sensitive to the service users’ feelings of hopelessness or despair. For example, several participants identified that some clients had felt at “*rock bottom*” at some points (participant 10). For very depressed or hopeless service users there was a need to “*let things ease*” (participant 9). Several nurses identified that



using medication or other physical interventions (e.g. ECT) could enable the individual to “*stabilise*” or maintain “*an optimal level of health and functioning*” (participants 1, 2) before making suggestions or having discussions about the future.

**Modifying factors.** Developing the therapeutic relationship was based on removing the “*barrier*” (participant 6) or “*divide*” (participant 8) between the nurse and service user, reflecting recognition of a power differential between the two. The nurses’ ability to break down these divides was influenced by the *context of the restricted environment*. The need to manage the therapy aspect of their role with the inherent security element of the forensic setting was seen by some as potentially impeding the development of a relationship. Participant one suggested that service users could see her “*as a prison officer*” rather than a nurse whilst participant two spoke of how difficult it could be for the service user to “*trust [you], when next thing, you’re going through ... their personal belongings*” (L 484-485).

### **Doing Reasonable Hope**

This category reflected the action-oriented processes through which the nurses aimed to develop hope with service users. These processes were influenced by their *beliefs about hope* as focussed on the future and the possibility of positive change.

Nurses worked with service users to provide information about different opportunities or possibilities, “*letting them know, that there are options*” (participant 1, L 120). The overall aim was to help the person to develop a *different imagined future*: “*making a patient believe that they can do better for themselves*” (participant 8, L 646-647). Nurses identified that this work was often difficult. Many service users found it challenging to imagine a different future as they had little “*evidence*” of previous hopeful or positive experiences to draw on: “*they think it’s always going to be like that, because it has always been like that*” (participant 4, L 195-196). Participant five described this as “*having to create hope from scratch*” (L 6). Some participants also cited the detrimental impact that negative media

representations of psychological problems had on service users' beliefs about themselves and their futures.

*'Doing hope'* was enacted in several ways. All of the nurses described setting and working towards *goals* as a hope-inspiring practice. Sometimes this was aided by the use of recovery-oriented tools (participants 2, 4, 7, 9), e.g. *"the Shared Care Pathway"* and techniques such as *"motivational interviewing"* or *"drawing diagrams of steps, with the goals at the top"*. The overriding purpose was to take a collaborative approach to help the service user *"come to some of their own conclusions"*: *"you sow all the seeds and then you see where, you know, what they want..."* (participant 4, L 495). Nurses worked to identify *goals* and to help the person develop the means or *"tools"* (participant 8) through which to achieve them: *"it's about where are you, and where do you want to be? And how are we going to get you there?"* (participant 1, L 125-130). They also provided examples of celebrities, peers or other individuals they had worked with who were further along in the recovery process, in order to build a *positive story/narrative*: *"You can say, 'Look. You see that person there? You've heard of them, this person, yeah? Well they suffer with the same thing that you do' and it's kind of a physical reminder of 'look what can be achieved'"* (participant 1, L 168-172).

Eight nurses highlighted the need for hopes and goals to be *"realistic"* in order to protect against disappointment. For example, participant four identified *"you don't want people to give up, aim too high and then give up"* (L48-49). At the same time, participants acknowledged the need to avoid crushing or *"poo-pooing"* (participant 1) an individual's potentially fragile sense of hope: *"to take that away from them at a time when they're low, maybe ... that's not a particularly prudent thing to do"* (participant 10, L 950-954). Nurses negotiated this balance through *"parking"* or *"acknowledging"* the person's goal (participant 7) whilst helping them to break it down into smaller, *"baby steps"* or using open questions to explore how the person thought they could meet their goals (participants 6, 9, 10). The nurses' descriptions suggested that they tried to avoid making a moral judgement

about hope or *“imposing”* hopes or goals on to the person (participants 1, 4, 6, 8, 9). This was summarised by participant nine: *“It’s about getting the patient really, to kind of think about what’s realistic. Rather than us say ‘that’s unrealistic’ or ‘that’s realistic’, you know. It’s about kind of supporting the patient in finding that out.”* (L 114-116). These views connected with Weingarten’s (2010, p.7) proposal of *‘reasonable hope’* as *‘both sensible and moderate, directing our attention to what is within reach more than what may be desired but unattainable’*.

**Modifying factors.** Being in a *restricted environment* modified the *‘doing’* of hope in several ways. The context of the secure unit led nurses to see the service users’ hope as residing predominantly in their progress through the secure unit to conditions of less restriction: *“people typically work their way through the wards and the golden prize is to get to [the rehabilitation unit] where after that it’ll probably be discharge”* (participant 2, L 317-320).

Nurses also saw the secure environment as uncertain and *“disempowering”* for service users. For example, some participants reflected on the impact to service users’ hope of lacking control to complete even basic tasks such as *“making a cup of tea”* or *“going to the bathroom”* (participant 1). This recognition led nurses to emphasise the need to develop hope by *giving back control* and *maintaining service user choice* (participants 1, 3, 4, 7, 8, 10) whether over very small things (*“what mug their tea’s in”*, participant 5, L 494) to decisions about their future. Taking control was seen as encouraging the person to take ownership or *“responsibility”* for their own mental health and care. Nurses identified that it was difficult to provide *“concrete timescales or facts”* (participant 2) to service users, which had a negative impact on hope. To mitigate this impact, nurses saw it as helpful to be with the service user at different points during their *“journey”* through the unit (participants 1, 2, 3, 4, 6, 8) in order to *“benchmark”* progress: *“They almost have a laugh about it like ‘Oh yeah, you were there with me for this or for that, or you were there with me at this point in time, and look where I am now’”* (participant 2, L 424-426). The concept of hope

as “a journey” with the service user was evident in many of the nurses’ descriptions. For example, analogies included “climbing a mountain”, “driving a car” and going on “an emotional rollercoaster together” (participants 8, 10).

### **Emotional Impact**

Whilst nurses described *holding hope* for another person as a fundamental element of their role, it was also experienced as “challenging” (participant 8) or “difficult” (participant 3) work and had an *emotional impact*. This category reflected the range of emotional responses and ways of managing these that were present within the data.

Several nurses described the positive impact or sense of reward of witnessing a person they had worked with become hopeful. For example, participant six described the sense of “achievement” and “accomplishment” they experienced when supporting a high-risk individual to address their mental health and offending behaviour. Participant two described “feeling great” when an individual they worked with made progress and attended a community-based college. Participant ten also identified that they had developed a greater level of self-awareness, as “always looking out for the positives” in their work with service users had “taught me a lot about myself” (L 690).

Nurses identified other times when they experienced a more negative impact of their work. Participant seven described “feeling stuck” when working to help a colleague support a very hopeless individual: “And that was quite hard ... as I always hope that I can come up with something” (L 351-352). Participant eight spoke of questioning and doubting themselves when a service user they had worked with returned from a lower level of restriction (on a rehabilitation ward) to the acute ward: “I was thinking ‘Have I failed him? Did I not help him?’” (L 299-300). Another participant described feeling “cynical” at times: “You’re trying to do your best, you’re trying do as much as you can ... but is it actually going to result in anything? And that’s being really honest” (Participant 3, L 223-228). Such descriptions connected to

feelings of powerlessness and hopelessness, and a struggle to maintain hope: “*so it’s a constant, well not a battle as such...*” (participant 2, L 199).

Nurses described several ways in which they managed the negative emotional impact of the work. A *hopeful team* atmosphere or ethos was seen as important; participant five spoke of “*the buoyancy you get from the people around you, your fellow workers, that’s helpful*” (L 318-319). Participant five also spoke of the difficulty maintaining their sense of hope when working in a very “*negative*” team in the past. Participants six and eight highlighted the importance of other staff receiving training in the recovery model in order to work in a consistent manner and promote an atmosphere of hope and recovery. This was seen to reflect a broader, ‘hopeful culture’ which nurses felt was required to successfully foster hope with service users.

In addition, several nurses highlighted supervision or more informal discussions with colleagues as providing a sense of “*perspective*” when they “*[couldn’t] see the wood for the trees*” (participant 3, L 204). However participant two suggested: “*there’s still room for development in terms of nursing staff of what clinical supervision is*” (participant 2, L 592-594). Supervision was seen as most helpful when it provided space for reflection on clinical work rather than more management based discussion.

Nurses also spoke passionately of the need to recognise the limits of their role. For example, participant eight described realising after some time in the role that they were not a “*[magic] wand*” and could not “*cure everyone*”. Analysis of the data indicated that nurses separated their personal response from their professional values at times when they experienced an emotional impact of their work. For example, participant eight described their “*professional body kicking in*” when an individual who had been discharged later returned to the secure unit. Participant two managed their emotional response in a similar way: “*but then you think ... ‘another day at the office’ that kind of thing, and carry on working with them*” (participant 2, L 459-461). Participant five discussed that “*even though it sounds a bit cold*” there was a need to “*move on*” or cut off from negative feelings at times as a way of

*“protecting”* themselves.

**Reciprocal relationship of hope.** Analysis of the data indicated that fostering or inspiring hope was not a one-way process from nurse to service user. The nurses’ hope influenced the service users’ hope and vice versa: *“It’s a two-way, you know – it’s collaborative, they care too back for you”* (participant 8, L 162). This mutual or *reciprocal relationship* modified the nurses’ emotional response; as participant two highlighted: *“One patient can affect a whole staff team”* (L 208). One participant described the challenges in maintaining their own sense of hope whilst working with individuals with complex needs: *“promoting hope within yourself, it’s difficult sometimes ... there are moments where you just sigh, and think ‘God’”* (participant 8, L 226-227).

The data analysis also indicated a *reciprocal relationship* between the practices through which the nurses fostered hope with service users (*doing reasonable hope*) and the ways in which they maintained their own sense of hope, with several overlaps between the two. For example, remaining focussed on *“the positives”* (participant 10) and drawing on their own past experiences, in a similar way to providing examples of positive change to service users. Participant two stated: *“if you’ve seen lots of people go through it then I think you can think ‘well, this is just them now. They might not always be this difficult to engage”* (L 473-476). For some nurses, this included drawing on personal experiences, which participant seven spoke powerfully about: *“Personal, shitty experiences ... things that go horribly wrong in your life ... I had choices to make, about whether I went down with the doom and gloom of what was happening, or I found something positive”* (L 380-384).

Conceptualising *hope as a journey* helped the nurses to hold on to their own sense of hope and to communicate the inevitable *‘peaks and valleys’* of life to the people they worked with (as described by Flesaker & Larsen, 2012). Participant eight summarised this outlook: *“So, how I talk with the patients is ... you’re gonna have your ups. And you’re gonna have*

*your downs. And there's always gonna be a steady bit as well. There's a few twists and turns along the way"* (L 638-642). In addition, emphasising the service users' choice and autonomy (maintaining "*a little bit of responsibility in their camp*", participant 10, L 335) prevented the nurses from carrying too much personal responsibility for the service users' behaviour. For example, participants seven and eight emphasised the need to permit service users to make their own *choices*, even when these were seen as unwise or likely to result in a negative outcome.

## Discussion

This study utilised a social constructionist GT methodology to explore mental health nurses' experiences of fostering hope within a forensic setting. Data analysis resulted in the development of a framework that integrates the nurses' *beliefs about hope*, the practices through which they aim to foster hope and the *emotional impact* of this work on the nurses' personal hope. The model posits a *reciprocal relationship* between the nurse and service users' hope; and between the practices through which the nurse nurtured their own and the service users' sense of hope. Prior to this study, such integrated models have been lacking across the general mental health literature and across the forensic mental health literature in particular.

Numerous researchers and policy makers have suggested the importance of practitioners '*carrying*' hope for the people they work with (e.g. Darlington & Bland, 1999; Sainsbury Centre for Mental Health, 2009). However detail about how this is achieved has been lacking, and therefore the clinical utility of such suggestions has been limited (Sexton, Ridley & Kleiner, 2004). The current study outlines more clearly what it means for mental health nurses to 'hold on to hope'. The overarching category *holding on to hope* relates to hope as both a personal and professional value, and captures the nurses' attempts to maintain a genuine and unconditional sense of hope for the people they work with. Such values connect with the writing of Roberts (1978) and Vaillot (1970) (in Stephenson, 1991) who proposed that fostering hope is an important aspect of the professional nursing role. Practitioners in previous research have spoken of the need to have 'genuine'

hope for the people they work with (Darlington & Bland, 1999; Cutcliffe & Grant, 2001; Koehn & Cutcliffe, 2012; Yohani, 2012). These findings reflect recent changes to the way in which staff are recruited to the NHS. Values-based recruitment focuses on an individual's values and alignment of these with the principles of the health service including compassion, acceptance and person-centred care (Health Education England, 2014; NHS, 2013).

The nurses' outlook on hope and their values underpinned the practices through which they aimed to foster hope with service users. These practices were captured under two categories: *being the intervention* and *doing reasonable hope*. The development of the therapeutic relationship was seen as "*imperative*" to form the base from which nurses were able to work on the "*deeper stuff*" (Participant 8). From here nurses were able to collaboratively explore possibilities for the future and set goals building up the "*evidence*" (participant 5) for hope. Such work was seen to further strengthen the therapeutic relationship: for example, participant ten spoke of "*flip-flopping*" between the two categories.

Previous research with both staff (Cutcliffe, 2004; 2006a; Koehn & Cutcliffe, 2012; Larsen & Stege, 2010a; McCann, 2002; Yohani, 2010) and service users (Hobbs & Baker, 2012; Borg & Kristiansen, 2004; see also Vass, 2011a) in general mental health settings has pointed to the importance of the therapeutic relationship in developing hope. Adshead (1998, 2002) suggests that therapeutic relationships in forensic settings provide the secure base from which individuals can experience a sense of psychological safety and re-experience themselves as capable of forming healthy attachments to other people. In line with Lemma (2004) it is suggested that hope is activated through an internalised relationship with the mental health practitioner who acts as the '*reflective*' and '*tolerant*' '*good object*'. The current study finds mental health nurses foster hope by *attuning to* and being sensitive to the individual needs of the service user, through demonstrating a non-judgemental, empathic approach. These characteristics reflect core humanistic principles (Rogers, 1961), which have been linked to the recovery model (Roberts & Wolfson, 2004).



The category *doing reasonable hope* has a clear future-orientation and comprises a focus on making progress, setting goals and providing choice/opportunities. This orientation reflected the nurses' beliefs and conceptualisation of hope. Many of the uncertainties inherent within the forensic setting – for example, length of stay and discharge date – led to a greater focus on external 'benchmarks' of progress such as movement through the unit and gaining additional responsibilities/opportunities (e.g. leave). Vass (2011b, p. 49) found a similar focus on '*external markers of progress*' amongst a sample of service users in the same secure setting. Likewise, individuals in Vass's study emphasised the importance of setting 'realistic' goals. Weingarten (2010) suggests that setting realistic goals helps practitioners and service users to take action towards desired outcomes, thereby fostering hope rather than feeling daunted by the often '*lofty*' expressions of what it means to feel hopeful. However, it is also important for nurses to feel psychologically safe and secure enough to tolerate uncertainties and hopelessness (Adshead, 2002; Carr & Havers, 2012). Otherwise, the risk is that nurses may feel compelled to 'do' more and more, to the detriment of '*being with*' the service user (Deegan, 1987; Houghton, 2007). Deegan (1987) points out that this position is very likely to end in staff frustration and ultimately '*giving up*'.

The current study also illustrates the *reciprocal or mutual relationship* between nurse and service user hope. These findings replicate those of Crain and Koehn (2012) who found that counsellors' sense of hope was inextricably linked to the hope of their clients. In the current study, nurses described a positive as well as negative impact of working to foster hope. The need to maintain hope and belief in the face of doubts, client despair or the client not being ready or willing to accept support connects to Hochschild's (1983) theory of emotional labour, which has previously been applied to nursing (e.g. Smith, 1992 in Gray, 2009). The theory describes the effort involved in displaying or expressing emotions (in this case, hope) expected of a particular professional role. Henderson (2001) suggests that nurses may manage the emotional demands of their work by moving along a continuum of '*engagement*' with and '*detachment*' from the patient. Such

detachment was evident in the descriptions of nurses to manage feelings of hopelessness: e.g. relying on the “*professional body kicking in*” was seen to protect participants from the personal emotional impact of their work. Cowan (2014) found a similar mechanism was utilised to protect staff working in forensic mental health care settings against vicarious traumatisation. Such a strategy may therefore be adaptive. For example one participant described that maintaining a clear division between her “*personal*” and “*professional*” self enabled her to foster hope with individuals for whom her personal background would make it difficult to engage. However emotional labour has been linked to increased stress amongst mental health nurses (Mann & Cowburn, 2005). Continually high emotional demands may increase the risk of the nurse becoming permanently detached from the people they work with. This could be seen in participants’ descriptions of other nurses who had become “*cynical*” and lost hope.

### **Implications for Clinical Practice**

The current study suggests that *holding on to hope* reflects a genuine belief in hope as a personal and professional value. Flesaker and Larsen (2012) suggest that hope is a skill that can be learnt. In the current study, nurses suggested that whilst a person could not be “*taught*” to have genuine hope (participant 1) professional training could help to develop an individual’s understanding and “*self-awareness*” of hope (participant 5) and hope-fostering practices. Larsen et al. (2013) propose that psychologist training should include conversations about hope and normalise experiences of low hope. The current findings suggest that such conversations should be included in training across a broad spectrum of mental health specialities. Several nurses in the current study identified that their hope was maintained by being with a service user at different stages along their journey through the secure unit. Participants acknowledged a potentially damaging effect of only ever working with service users towards the beginning of their journey, where levels of distress are likely to be higher. The opportunity to reflect with the service user on the progress made and look towards the future was seen as hope-inspiring. These findings have implications for those involved in the management and organisation of service delivery in secure settings.

Attuning to the needs of the service user and developing a therapeutic relationship were seen as vital to develop hope. However such work presents emotional challenges for staff. Clinical psychologists are well placed to provide space, for example through reflective groups, joint formulation sessions or supervision, to ensure that staff feel adequately supported and equipped to tolerate the '*vicissitudes of hope and despair*' particularly when working with more chronic or complex mental health difficulties (Russinova, 1999). It is suggested that a psychological approach such as the Acceptance and Commitment (ACT) (Hayes, Strosahl & Wilson, 2011) model may provide a helpful framework in which to situate hope, both for staff and service users. In line with the ACT model, staff and service users could draw on mindfulness techniques to promote a stance of openness and acceptance towards all internal states, whether positive or painful; and to act in accordance with their values and chosen life direction (Harris, 2009). These two aims have clear overlaps with the categories of *being* and *doing* hope and may support staff to negotiate the balance between the two.

Finally, some nurses suggested that an increasing societal and organisational focus on managing risk (predominantly of harm to others) is at odds with work to foster hope. The difficulties in implementing recovery models in forensic settings, where a focus on risk is often seen as paramount, have previously been outlined (e.g. Green et al., 2011; SLAM/SWLSTG, 2010). In line with the suggestions of Kaliski & de Clerq (2012) nurses conveyed that despite potential setbacks, the overall aim was for the client to regain control and be able to exercise choice. However in a community-based study, Tickle, Brown and Hayward (2012) found that psychologists felt unable to promote service user autonomy and self-management due to risk-related concerns. Further questioning in regards to risk may have developed an understanding of how nurses in the current study negotiated the balance between the therapeutic and security aspects of their role. However, analysis revealed other issues to feature more significantly in the nurses' accounts of fostering hope. Potentially nurses

may have seen decisions regarding risk as residing with other members of the MDT (e.g. the responsible clinician, often a doctor). Future research may benefit from further exploring how practitioners in MDTs across both secure and community settings negotiate a balance between fostering hope and managing risk.

## **Limitations**

The current study aimed to explore the specific phenomenon of hope within a particular situational context of mental health nursing in a forensic setting. Therefore it can be thought of as a substantive grounded theory (e.g. Strauss & Corbin, 1990). Similarities between the framework proposed here and other staff and service user views within the literature suggest that the framework may be transferable or 'fitting' to other similar contexts (for example, low or high secure forensic mental health settings or community forensic services) (Chiovitti & Piran, 2003). However, further research is required to test out whether the current framework has meaning for individuals in such settings.

Throughout the data collection and analysis, steps were taken to enhance the quality and rigour of the analysis and findings. These steps included the use of memos to uncover and examine the influence of the researcher's preconceptions. Memo-writing also helped to ground the analysis in data and aided the constant comparison of emerging categories with earlier codes as analysis progressed. External validation may have been further enhanced through further respondent validation; for example, returning to participants following construction of the framework to obtain their views regarding its' credibility. However Payne (2007) points out that this technique may result in the generation of more data from differing perspectives rather than establishing the validity of one particular perspective. As such this technique may be less relevant to GT (Tweed & Priest, 2015). Steps were taken to ensure the credibility and transparency of the analysis through testing out of tentative categories with participants in later interviews and sharing sections of coding with other peers and supervisors well-experienced in the use of GT (see Paper 3 for further details

of rigour in line with guidelines provided by Elliott, Fischer & Rennie, 1999).

It is likely that nurses who took an interest in and felt strongly about hope were more likely to volunteer to take part in the study. Whilst participants in the study spoke of nurses who had lost hope, it is acknowledged that the voices of these nurses are missing from the data. However, the grounded theory that emerged has been used to make hypotheses about how nurses may lose a sense of hope. Future research could aim to test out these hypotheses, perhaps by recruiting ex-nurses. The model that emerged from the data provides one interpretation of nurses' experience of hope in a male, medium secure mental health setting. Further research is required to test out and develop this model across a broader range of mental health settings and staff.

In regards to reflexivity, the social constructionist stance of the researcher meant that they did not attempt to bracket off their previous experiences and pre-conceptions but to examine their influence on the data. Steps were taken to ensure that the model was grounded in the data. It is possible that the researcher's experience of working with a forensic setting and beliefs about recovery subconsciously influenced the analysis. For example, it is noted that the model of hope constructed in the current study overlaps with research that has explored how mental health practitioners facilitate service users' recovery (e.g. Aston & Coffey, 2012; Borg & Kristiansen, 2004) (see Paper 3 for further discussion of reflexivity).

## **Conclusion**

The nurses' beliefs about hope and the practices through which they worked to foster hope share many similarities with the perspectives and hope-inspiring practices of practitioners within other mental health settings. However the current study highlighted particular challenges of fostering hope with a medium secure setting. Nurses had to negotiate the therapeutic and security related elements of the role in order to develop trusting relationships with service users. They were also required to maintain service users' hope within the often uncertain and sometimes disempowering context of the

secure setting. There was an increased focus on making progress against concrete goals and being with the service user at different stages of their journey through the secure unit. The model of hope that was constructed requires further testing across different settings and practitioners. However the findings suggest that recruitment and training of mental health care staff should aim to promote hope-fostering practices. Clinical psychologists have a role to play in supporting staff to translate hopeful values and orientation into practice and to monitor their own level of hope.

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## Appendices

### Appendix

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## Appendix 1 Journal of Forensic Psychiatry and Psychology Instructions for Authors

The following information is taken from the Journal's website.

*The Journal of Forensic Psychiatry and Psychology* is a multidisciplinary journal devoted to publishing papers relating to aspects of psychiatry and psychological knowledge (research, theory and practice) as applied to offenders and to legal issues arising within civil, criminal, correctional or legislative contexts.

Throughout the world, psychiatrists, psychologists, criminologists, lawyers, sociologists, nurses, social workers and other legal and medical professionals use this journal as their major forum for penetrating, informed global debate on the latest developments and disputes affecting the practice of forensic psychiatry.

*The Journal of Forensic Psychiatry and Psychology* publishes in-depth case studies, current research and short articles on mental health, crime and the law. This acclaimed journal is essential to all serious psychiatric or legal collections.

**Peer Review:** All submitted manuscripts are subject to initial appraisal by the Editor, and, if found suitable for further consideration, to peer review by independent, anonymous expert referees. All peer review is double blind and submission is online via ScholarOne Manuscripts.

### Manuscript preparation

#### 1. General guidelines

Manuscripts are accepted only in English. Any consistent spelling style may be used. Please use single quotation marks, except where 'a quotation is "within" a quotation'. Long quotations of 40 words or more should be indented without quotation marks. Always use the minimum number of figures in page numbers, dates etc., e.g. pp. 24-4, 105-6 (but using 112-13 for 'teen numbers) and 1968-9.

A typical manuscript will not exceed 5,000 words not including references. Manuscripts that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript. Review papers (e.g. systematic reviews, meta-analyses, law reviews) and some empirical studies may require greater length and the Editors are happy to receive longer papers. We encourage brevity in reporting research. Brief reports should be no more than 2,000 words in length, including references.

Normally, there should be a maximum of one table.

Manuscripts should be compiled in the following order: title page (including Acknowledgements as well as Funding and grant-awarding bodies); abstract; keywords; main text; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).



Please supply all details required by any funding and grant-awarding bodies as an acknowledgement in a separate Funding paragraph as follows: For single agency grants This work was supported by the <Funding Agency> under Grant <number xxxx>.

For multiple agency grants: This work was supported by the <Funding Agency #1> under Grant <number xxxx>; <Funding Agency #2> under Grant <number xxxx>; and <Funding Agency #3> under Grant <number xxxx>.

Abstracts of 150 words are required for all manuscripts submitted.

Each manuscript should have 3 to 6 keywords .

Search engine optimization (SEO) is a means of making your article more visible to anyone who might be looking for it. Please consult our guidance [here](#).

Section headings should be concise.

All authors of a manuscript should include their full names, affiliations, postal addresses, telephone numbers and email addresses on the cover page of the manuscript. One author should be identified as the corresponding author. Please give the affiliation where the research was conducted. If any of the named co-authors moves affiliation during the peer review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after the manuscript is accepted. Please note that the email address of the corresponding author will normally be displayed in the article PDF (depending on the journal style) and the online article.

All persons who have a reasonable claim to authorship must be named in the manuscript as co-authors; the corresponding author must be authorized by all co-authors to act as an agent on their behalf in all matters pertaining to publication of the manuscript, and the order of names should be agreed by all authors.

Biographical notes on contributors are not required for this journal.

Authors must also incorporate a Disclosure Statement which will acknowledge any financial interest or benefit they have arising from the direct applications of their research.

For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms must not be used.

Authors must adhere to SI units. Units are not italicised.

When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.

Books for review should be sent to the Book Review Editor, Dr Mary Whittle, John Howard Centre, 12 Kenworthy Road, London, E9 5TD, UK.

Case reports should be accompanied by the written consent of the subject. If a subject is not competent to give consent the report should be accompanied by the written consent of an authorized person.

## 2. Style guidelines

Description of the Journal's article style.

Description of the Journal's reference style.

Guide to using mathematical symbols and equations .

Taylor & Francis Online The Journal of Forensic Psychiatry & Psychology -  
Instructions for authors 05/12/2014 18:07

<http://www.tandfonline.com/action/authorSubmission?journalCode=rjfp20&page=instructions#.VIH0D0uKspE> Page 3 of 4

Word templates are available for this journal. If you are not able to use the template via the links or if you have any other template queries, please contact [authortemplate@tandf.co.uk](mailto:authortemplate@tandf.co.uk) .

## 3. Figures

Please provide the highest quality figure format possible. Please be sure that all imported scanned material is scanned at the appropriate resolution: 1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour.

Figures must be saved separate to text. Please do not embed figures in the manuscript file.

Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).

All figures must be numbered in the order in which they appear in the manuscript (e.g. Figure 1, Figure 2). In multi-part figures, each part should be labelled (e.g. Figure 1(a), Figure 1(b)).

Figure captions must be saved separately, as part of the file containing the complete text of the manuscript, and numbered correspondingly.

The filename for a graphic should be descriptive of the graphic, e.g. Figure1, Figure2a.

## Appendix 2 Correspondence with Editor, Journal of Forensic Psychiatry and Psychology

paper – NIEBIESZCZANSKI Rebecca

13/10/2014 15

paper

Jenny Shaw [REDACTED]

Mon 13/10/2014 08:28

Inbox

To: NIEBIESZCZANSKI Rebecca [REDACTED]

Dear Rebecca

I am sorry i missed your previous email, I was having problems with my email a couple of weeks ago. I would suggest that you submit your paper as the topic area sounds appropriate. we will look at it and assess whether to get it peer reviewed.

best wishes

Jenny Shaw

Submission to Journal of Forensic Psychiatry & Ps... [REDACTED]

13/10/2014 19:45

## Submission to Journal of Forensic Psychiatry & Psychology - Query

[REDACTED]  
Tue 30/09/2014 11:15

Sent Items

To: jennifer.j.shaw@manchester.ac.uk <jennifer.j.shaw@manchester.ac.uk>;

Dear Professor Shaw,

I am currently in the process of conducting a piece of research as part of my doctoral training. I believe that the study may reflect the aims and scopes of the Journal of Forensic Psychiatry and Psychology and would be keen to submit a manuscript for consideration of the editorial board. However I wondered if you may be able to provide some feedback as to whether a submission would be appropriate?

The study is a qualitative piece of research, using a Grounded Theory methodology. The study aims to explore the beliefs that staff working in a forensic mental health setting have about instilling hope with the service users they work with, and what practices they employ with the aim of instilling hope. It is envisaged that the study will have relevance to a broad range of practitioners working in forensic and secure mental health settings, which I feel suits the readership of the Journal. It also has relevance to organisations and services that are developing ways of working in the recovery model. It is projected that the complete manuscript will be 7,500 word approx., and I also wondered whether a piece of this length would be considered?

Thank you very much in advance for your assistance.

Yours sincerely,

Rebecca Niebieszczanski

### Appendix 3 Health Sciences Ethical Panel Approval



Faculty of Health Sciences

#### ETHICAL APPROVAL FEEDBACK

Researcher name:	Rebecca Niebieszczanski
Title of Study:	Instilling hope within a forensic mental health setting: A Grounded Theory of staff beliefs and practices
Award Pathway:	DClinPsy
Status of approval:	Approved



#### Action now needed:

Your project proposal has now been approved by the Faculty's Ethics Panel and you may now commence the implementation phase of your study. You do not need to approach the Local Research Ethics Committee. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

#### Comments for your consideration:

Thank you for forwarding the amendments requested by the Panel

  
Signed:   
Chair of the Faculty of Health Sciences Ethics Panel

Date: 5<sup>th</sup> December 2013

## Appendix 4 NHS Trust Research and Development approval

[Redacted]  
NHS Foundation Trust



Our Ref: AB/R292

2 May 2014

Ms Rebecca Niebieszcanski  
Trainee Clinical Psychologist  
Faculty of Health Sciences, Science Centre  
Staffordshire University  
Leek Road  
Stoke on Trent  
ST4 2DF

Dear Rebecca

### Letter of access for research

This letter should be presented to each participating organisation before you commence your research at that site [Redacted] Trust.

In accepting this letter, each participating organisation confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. This right of access commences on **1 May 2014** and ends on **30 September 2015** unless terminated earlier in accordance with the clauses below.

As an existing NHS employee you do not require an additional honorary research contract with the participating organisation. The organisation is satisfied that the research activities that you will undertake in the organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this organisation that the necessary pre-engagement checks are in place in accordance with the role you plan to carry out in the organisation. Evidence of checks should be available on request to [Redacted] Trust.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving the organisation permission to conduct the project.

You are considered to be a legal visitor to [redacted] Trust premises. You are not entitled to any form of payment or access to other benefits provided by [redacted] Trust or this organisation to employees and this letter does not give rise to any other relationship between you and [redacted] Trust, in particular that of an employee.

While undertaking research through [redacted] Trust you will remain accountable to your employer [redacted] but you are required to follow the reasonable instructions of your nominated manager **R&D Manager** in each organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with [redacted] Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with [redacted] Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on [redacted] Trust premises.

Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and each participating organisation prior to commencing your research role at each site.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

The organisation will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that the organisation accept no responsibility for damage to or loss of personal property.

This letter may be revoked and your right to attend the organisation terminated at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of the organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the organisation that employs you through its normal procedures. You must also inform the nominated manager in each participating organisation..

Yours sincerely

[Redacted Signature]  
[Redacted Name]  
R&D Manager

cc: HR department, [Redacted Name]  
[Redacted Name]

Our Ref: AB/R292

02 May 2014



Ms Rebecca Niebieszczanski  
Trainee Clinical Psychologist  
Faculty of Health Sciences, Science Centre  
Staffordshire University  
Leek Road  
Stoke on Trent  
ST4 2DF

Dear Rebecca

**Study title: Staff beliefs about instilling hope in a secure care setting**

We have considered your application for access to patients and staff from within this Trust in connection with the above study.

On behalf of the Trust and the Responsible Care Professionals within the Psychology Directorate have now satisfied themselves that the requirements for Research Governance, both Nationally and Locally, have been met and are happy to give approval for this study to take place in the Trust, with the following provisos:

- That all researchers coming into the Trust have been issued with either a letter of access or honorary contract by ourselves
- That you conform to the requirements laid out in the letters from the University Ethics Panel dated 5 December 2013, which prohibits any changes to the agreed protocol
- That you keep the Trust informed about the progress of the project at 6 monthly intervals
- If at any time details relating to the research project or researcher change, the R&D department must be informed.

Your research has been entered into the Trust database and will appear on the Trust website.

As part of the Research Governance framework it is important that the Trust are notified as to the outcome of your research and as such we will request feedback once the research has finished along with details of dissemination of your findings. You will be asked to provide a copy of the final report and receive an invitation to present final feedback via our research seminar series. To aid dissemination of findings, copies of final reports are placed on our Trust Website. To this end, please



contact me towards the completion of the project to discuss the dissemination of findings across the Trust and a possible implementation plan.

If I can help in any other way please do not hesitate to contact me.

Yours sincerely

A solid black rectangular box used to redact a signature.

R&D Manager

## Staffordshire & Keele Universities

### Doctorate in Clinical Psychology

#### DClinPsy

Faculty of Health Sciences, Staffordshire University,  
Leek Road, Stoke-on-Trent ST4 2DF

E [DClinPsy@staffs.ac.uk](mailto:DClinPsy@staffs.ac.uk)

T +44 (0)1782 - 294007

W <http://www.staffs.ac.uk>



Keele University

Participant Information Sheet version 1: 27<sup>th</sup> March 2014

#### Participant Information Sheet

##### **Instilling hope within a forensic mental health setting: A Grounded Theory of staff beliefs and practices**

You have been invited to take part in a research study about hope. We are interested in finding out what hope means to you, your thoughts about hope and your views about instilling hope in service users. The study is being undertaken by Rebecca Niebieszczanski as part of a Doctorate in Clinical Psychology qualification at the Universities of Staffordshire & Keele. Please read through this information sheet to help you decide whether you would like to take part in the study. You will have at least 24 hours to decide. Please contact the research team (details below) if you have any questions.

##### **What is this research study about?**

We are aiming to speak to staff who work with service users in secure mental health settings. We would like to understand how staff in these settings think about hope, what their thoughts are about instilling hope in service users and the behaviours they engage with in order to instil hope. It is important to develop a greater understanding of this area in order to identify any barriers or challenges that staff members experience when trying to instil hope in service users in forensic settings. We can then consider how to address these. Overall we aim to identify the strategies that staff members use to inspire hope in service users in forensic mental health settings. The findings from this study could be tested out in different settings and compared to the views and experiences of service users.

##### **Who will be taking part?**

Staff members who currently work in secure care services. We are aiming to involve between 10 and 12 participants in the study.

##### **What will it involve if I choose to take part?**

It is up to you whether you decide to take part in the study, and you are under no obligation to do so.

If you choose to take part you will be invited to talk about your views about what hope means to you, your beliefs about hope and your views about instilling hope in the service users that you work with. You will be also asked some questions about

anything you do with the aim of instilling hope in service users. There are no right or wrong responses or opinions; we are just interested in hearing your views. You do not have to talk about anything that you are uncomfortable about. The interview will last about 60 minutes and will be audio recorded. The researcher will also make some additional notes about anything else they observe during the interview. The interview will take place in a private room at your location. We will also take a record of your age, gender, ethnicity, your job role and the length of time you have been employed in this role. This will help us to get an idea of the characteristics of the staff who take part in the study.

All the information that you provide will be kept confidential and seen only by the researcher and the researcher's supervisors (see details below). We would only discuss the information with someone else if there was any indication of a risk of harm to someone (yourself, other staff, service users or members of the public) or criminal activity. The audio recordings will be locked securely and only available to the research team. The audio recording will also be transcribed. Any information that could identify you will be removed from both the audio recording and the transcript. Your name will not be used and your interview will be assigned an anonymous code.

The information from the interviews will be analysed in accordance with the methods of Grounded Theory (GT). GT is a well-established and rigorous method used in the social sciences. This will involve a process of creating categories from themes that emerge from the data. These categories may be altered as interviews are conducted and more data analysed. The end product will be a model of hope, grounded in the experiences of staff within forensic mental health settings, which the research team feels best represents the data. The findings will be written into a final report that will be submitted to a journal for publication. The information we ask about you will not be presented in a way that could identify you in any reports that may be published or disseminated to other interested parties. Some quotes from the tapes may be used but will remove any identifying information. In line with data protection and ethical guidelines, all data from the study will be stored securely for a 5 year period, after which time it will be destroyed. We will inform your line manager that members of staff may choose to take part in the study but we will not tell them anything that you say. If you would like to have a copy of your transcript, you can ask for this at any time during the interview. This will be made available for you to look at and contact details to discuss any issues with the researcher will be provided.

#### **What are the possible advantages and disadvantages of taking part?**

We cannot promise the study will help you directly. However we hope that the information we get from this study will develop our understanding of staff views, which we think is an under-researched area. We also think that the study will develop our understanding of how staff in a forensic mental health setting think about hope and what they do in order to instil hope in service users they work with.

We do not anticipate that the interview questions will cause you upset, however we recognise that you may become distressed by talking about your views and experiences with the research team. We will give you the opportunity to talk about anything that may have distressed you with a member of the research team, including a clinical psychologist. You do not have to answer any individual questions during the interview that you would prefer no to.

**Do I have to take part?**

It is up to you to decide to take part in the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form and provide you with a participation number. You are free to withdraw at any time before or during the interview, without giving a reason. We are very grateful for you reading this information, whether or not you decide to take part in the study.

**Can I withdraw from the study if I change my mind?**

You can choose to stop your involvement in the study at any time prior to taking part in the interview or at any point during it, and you do not need to give us a reason why. If you change your mind and decide that you would like to withdraw your data following the interview, we ask that you contact a member of the research team and provide the identification number given to you when you sign the consent form. This will allow us to remove your data from the study. Please note that you will be able to withdraw your data up until the point when the research has been submitted for publication.

**What should I do if I decide to take part?**

If you choose to take part then after at least 24 hours you will be asked to sign a consent form to say that you have read this information sheet and that you are happy to take part.

**Who is conducting this study?**

The lead researcher is Rebecca Niebieszczanski (Trainee Clinical Psychologist) who will conduct the interview. [REDACTED] (Clinical Psychologist based at the [REDACTED]) and Professor Helen Dent (Clinical and Forensic Psychologist, based at Staffordshire University) will supervise the research study. The contact details for members of the team are provided below.

**Who has reviewed this study?**

All research in the NHS is looked at by independent group of people, the Research Ethics Committee, to protect your interests. It has also been approved by the Research and Development department within [REDACTED] Trust.

**What if there is a problem?**

If you have any concerns please contact Rebecca Niebieszczanski on **01782 294007** or send an email to **n027424b@student.staffs.ac.uk**. You can also contact [REDACTED], who is based at the [REDACTED] on **01785 221420**. You can also contact Professor Helen Dent on **01782 294007**. If you remain unhappy and wish to complain formally, you can do this by contacting [REDACTED], Research Governance, [REDACTED]. Alternatively call [REDACTED] or email: [REDACTED].

**Further information**

If you would like any further information please contact Rebecca Niebieszczanski on 01782 294007 or email **n027424b@student.staffs.ac.uk**.

**Thank you for reading this information**

## Appendix 7 Consent form

Consent form version 1 27<sup>th</sup> March 2014



# **Staffordshire & Keele Universities**

## **Doctorate in Clinical Psychology**

### **DClinPsy**

Faculty of Health Sciences, Staffordshire University,  
Leek Road, Stoke-on-Trent ST4 2DF

E [DClinPsy@staffs.ac.uk](mailto:DClinPsy@staffs.ac.uk)

T +44 (0)1782 - 294007

W <http://www.staffs.ac.uk>



Keele University

### **Instilling hope within a forensic mental health setting: A Grounded Theory of staff beliefs and practices**

#### **Consent Form**

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated 27<sup>th</sup> March 2014 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered to my satisfaction. ☐
2. I understand that my participation is voluntary. I understand that I can change my mind and withdraw from the study at any point before the research interview or during it. I understand that if I change my mind following the interview, I will need to contact a member of the research team and provide the participant identification number given to me when I sign this consent form. I understand that I am able to withdraw my data up until the point when the research is submitted for publication, following which it will not be possible to remove my data. ☐
3. I understand that an audio recording will be made of the interview and the researcher will make some additional notes about the interview during it. I understand that the research team will ask me for some demographic information. This includes my age, gender and ethnicity, and some information related to my role and how long I have worked in the research setting. The purpose of this is to show the characteristics of the participants in the study. ☐
4. I understand that the researcher will transcribe the audio recording of the interview. I understand that only the research team will have access ☐

to the transcripts and audio records. Any information that could identify me will be removed from the recording and the transcript.

5. I understand that the research findings will be presented in a written report. This report will be submitted to a journal for publication. I understand that sections of the transcript or written record may be used in the presentation of the findings along with the demographic information about me. I am happy that anonymous data may be shared with the editorial board of any journal to which the research is submitted. I understand that the information in the final report will be presented in a way that does not identify me and it will be anonymous.

☐

6. I understand that the research team may contact me in order to check or ask further questions about responses during the research interview. My participation in any follow up questions is voluntary and I do not have to take part if I do not wish. I will be asked to sign another consent form if I choose to take part.

☐

7. I agree to take part in the above study.

☐

\_\_\_\_\_  
Name of participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of person  
taking consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

*(When completed, one copy for participant; one for research site file)*

Consent form version: [Number]

Consent form date of issue: [DATE]

-----  
**Please keep this number safe. We will ask you to provide this number in the event that you decide to withdraw your information from the study.**

**Participant identification number:**

## Appendix 8 Participant demographic details

Participant ID	
What is your job role?	
How long have you worked in this role?	
Approximately how long have you worked at [research site] for?	
What is your age (can be approx.)?	
How would you describe your ethnicity?	

## Appendix 9 Initial interview schedule (version 1)

### Interview schedule

#### Introductions (0 – 10 minutes)

Introduce myself and explain my role as a trainee clinical psychologist. Introduce the aims of the research (highlight it's part of my training and not being carried out on behalf of the organisation or NHS). Give participants a little information about my previous experience of working in forensic settings, and what led me to think that this is an important area to research.

Remind participants that their participation is voluntary; therefore they can choose to stop the interview at any time or choose not to answer any questions if they do not want to, without giving a reason.

Explain that it is not expected that the interview will cause participants any unnecessary distress; and that the questions, whilst personal, are not of an embarrassing or overly sensitive nature. However if unexpectedly, participants do experience any distress then I'll follow procedures outlined in the Information Sheet (PIS) - initially I'll try to clarify and address any concerns or distress raised. I'll also consult with the clinical supervisor immediately following the interview in order to offer support.

Discuss the limits of confidentiality, as outlined within the PIS. Remind participants that we'll record the interview, to aid data analysis, and that ultimately the research will be written up to submit as part of training and also hope to publish in a widely available journal. However everything they say will remain anonymous – names will be changed, no identifying information in the final report, any direct quotes will also be anonymous. Will also remain anonymous within the organisation – summary of the report will be shared at the Senior Nurses' Forum, this will also be anonymous. Ask the participant how they are feeling, and other general questions and whether they remain happy for the interview to go ahead.



Initial questions (10 – 30 minutes)

I wonder, could you tell me what the word 'hope' means to you? What does it mean to have hope?

*If the participant offers no meaning or definition, explain that hope is difficult to describe, as it means different things to different people. Suggest that some people think of hope as 'the belief that things can be better' (note: this is in line with Perkins, 2006). Others have suggested it involves a number of different aspects, such as optimism, recognising that help is available and believing that problems can be resolved (note: this is in line with Cook et al., 2005 & Shives, 1994).*

What do you think about that?

Can you tell me how hope is used (or not) in your work?

How important do you think it is for the service users you work with to maintain a sense of hope?

Prompts:     What if a service user felt hopeful?  
                  What if a service user felt hopeless?  
                  How important do you think hope is for a service  
                  user's recovery?

*(Check participant's understanding of the word recovery. If the participant is unsure give a definition phrased as: some people have said that recovery is a really personal process, that it's about someone's attitudes, values, feelings and goals changing, enabling them to have a satisfying life and contribute even if there are limitations caused by mental health difficulties. So it's about the development of new meaning and purpose in someone's life, as they grow beyond the effects of mental health difficulties (note: in line with Anthony, 1993).*

What impact/effect do you think having hope has on a service user's recovery?

Intermediate questions (30 – 50 minutes)

How do you think other staff use hope in their work?

How important it is for staff to help service users develop or maintain a sense of hope?

How do staff instil (inspire) or maintain hope with service users?

Prompts:     What do they say?  
                  What do they do?  
                  Similarities/differences between staff members?

What helps staff to instil or maintain hope with the service users they work with?

What do you think gets in the way/hinders that/makes it harder?

How do staff respond if a service user shares their hopes?

What impact (if any) does the organisation, or environment have on staff instilling/maintaining hope with service users?

How do you feel about instilling/maintaining hope with the service users you work with?

Prompts:     What do you say?  
                  What do you do?

What helps you to instil or maintain hope with the service users you work with?

What gets in the way/hinders/makes it harder?

Prompts: Without giving me their name(s), is/are there any service user(s) who you feel it is easy to inspire hope in or you feel very hopeful for? Why is that?  
Without giving me their name(s), is/are there any service user(s) who you feel it is difficult to inspire hope in or you feel very hopeful for? Why is that?

How did you learn to instil hope?

How has that changed over time?

What would you now say are the most important ways of instilling/maintaining hope with service users? How did you discover these?

Ending questions (50 - 60 minutes)

Is there something that you might not have thought about before that occurred to you during this interview?

Is there something else you think I should know to understand how you think about/work to instil hope with service users you work with better? Was there anything you would have liked to talk about/anything that has come to mind about hope, which I have not asked you about?

Is there anything you would like to ask me?

Is there something we have talked about that has made you feel different in any way? (Prompt: to explore any distress if appropriate)

Thank the participant for taking part. Let participants know that you may contact them to ask any further questions based on what we have talked about today, and check that they are still happy for this to happen (ask for contact details if not provided when consent form was signed). Debrief on nature of the study, ask for any feedback and if the participant is happy with the interview/any questions they may have.

#### Appendix 10 Adapted interview schedule (version 2)

- Introduce myself and explain role as a trainee clinical psychologist.
- Introduce the aims of the research (highlight it's part of my training and not being carried out on behalf of the organisation or NHS).
- Bit of information about my previous experience of working in forensic settings, and what led me to think that this is an important area to research.
- Participation is voluntary: can choose to stop or not answer any question.
- Distress: not expected that the interview will cause participants any unnecessary distress; and that the questions, whilst personal, are not of an embarrassing or overly sensitive nature. However if unexpectedly, participants do experience any distress then I'll follow procedures outlined in the Information Sheet (PIS). Initially I'll try to clarify and address any concerns or distress raised. I'll also consult with the clinical supervisor immediately following the interview in order to offer support.
- Confidentiality: Reminder of limits. Remind participants that we'll record the interview, to aid data analysis. Research written up and submitted for training and then aim to publish in Journal. However everything they say will remain anonymous – names will be changed, no identifying information in the final report, any direct quotes will also be anonymous. Will also remain anonymous within the organisation – summary of the report will be shared at the Senior Nurses' Forum, this will also be anonymous.
- Give broad overview of questions that will ask: what hope means to you; your views about developing hope with service users; will also check out some of the themes that have come from analysis of the interviews conducted so far – check out how much these reflect your own experiences, whether they make sense for you (or not). Ask the participant how they are feeling, and other general questions and whether they remain happy for the interview to go ahead. Ask demographics info.

1. Just to begin, I wondered if you could tell me a bit about what 'hope' means to you? What does it mean to have hope? *NB. 'The belief that things can be better' or, involves a number of different aspects, such as optimism, recognising that help is available and believing that problems can be resolved.* What do you think about that?
2. Can you tell me a bit about how hope is used (or not) in your work with service users?
  - What things do you do with the aim of instilling hope?
  - What about other members of the team? How do other staff use hope in their work?
3. Are there any challenges when working to instil hope? If so, what?
  - The theme of instilling 'realistic hope' has come out of previous analysis. What do you make of that idea?
4. One idea that's emerged from previous interviews is that of developing hope with service users as a 'journey'. I wondered how that fits with your experience?
  - Does the way you work to instil hope at different stages of the journey differ? If so, how?
5. Another idea is that nurses might find ways to make the concept of 'hope' less abstract, or more concrete, when talking about it or working to develop it with service users. How does that fit with your experiences?
  - Providing it with a human form, for example.
  - Can you give me any examples of how you do that?
6. How did you learn to instil hope?
7. How has that changed over time?
8. What impact (if any) do you think the organisation, or environment has on staff instilling/maintaining hope with service users?

#### Appendix 11 Adapted interview schedule (version 3)

- Introduce myself and explain role as a trainee clinical psychologist.
- Introduce the aims of the research (highlight it's part of my training and not being carried out on behalf of the organisation or NHS).
- Bit of information about my previous experience of working in forensic settings, and what led me to think that this is an important area to research.
- Participation is voluntary: can choose to stop or not answer any question.
- Distress: not expected that the interview will cause participants any unnecessary distress; and that the questions, whilst personal, are not of an embarrassing or overly sensitive nature. However if unexpectedly, participants do experience any distress then I'll follow procedures outlined in the Information Sheet (PIS). Initially I'll try to clarify and address any concerns or distress raised. I'll also consult with the clinical supervisor immediately following the interview in order to offer support.
- Confidentiality: Reminder of limits. Remind participants that we'll record the interview, to aid data analysis. Research written up and submitted for training and then aim to publish in Journal. However everything they say will remain anonymous – names will be changed, no identifying information in the final report, any direct quotes will also be anonymous. Will also remain anonymous within the organisation – summary of the report will be fed back to staff working here, this will also be anonymous.
- Give broad overview of questions that will ask: what hope means to you; your views about developing hope with service users; will also check out some of the themes that have come from analysis of the interviews conducted so far – check out how much these reflect your own experiences, whether they make sense for you (or not). Ask the participant how they are feeling, and other general questions and whether they remain happy for the interview to go ahead. Ask demographics info.

1. Thinking about what hope means in general – analysis of some other interviews suggests that it could be described as being very individual and different for different people. It is a belief in or anticipation of positive future change. This influences behaviour, by motivating a person to work towards desired goals and outcomes.
  - How does that fit with your own thoughts or experiences of hope? Are there any similarities or differences for you?
2. How important is hope to you in your role as a nurse?
  - What things do you do with the aim of instilling hope? Can you give me an example of a time when you helped a client to develop hope?
  - How important is it to have genuine hope?
  - How important is it that hope is realistic?
  - What about the idea of 'holding on to hope' for the service user/patient/client? What do you think about that? How do you do that?
3. Analysis of other interviews so far suggests that nurses might see their work in two broad areas as helping the service user to develop hope: by focussing on the development of a therapeutic relationship and through collaboratively working with the client to make progress and set/achieve goals (see examples attached)
  - How does that fit with your experience?
  - How do you develop a relationship with the client? What things affect you developing a relationship?
  - Are there any times when you focus more on one of these areas than the other?
4. Analysis so far also suggests that some of the things the nurse might do to develop hope with a service user also help the nurse to maintain their own sense of hope.
  - How does that fit with your experience? What helps you to maintain your sense of hope?

5. How does working to develop hope impact on you? Does it ever have an emotional impact? Have there been times when you have felt hopeless?
  - How do you manage this?
6. Does working in a forensic unit have any impact on how hopeful you feel for the clients/patients or the way you work to develop hope with them?
7. How did you learn to instil hope?
  - How has that changed over time?
8. Is there anything I have not asked you that you think is important about hope?



<b>‘Being the intervention’</b>
Developing a therapeutic relationship
<p>‘Attuning to the client’</p> <p>Getting to know the whole person (seeing beyond ‘mental illness’)</p> <p>Meeting the person on the same level (being non-judgemental)</p> <p>Being sensitive to feelings of hopelessness</p> <p>Getting to know how to meet the person’s needs – communication needs, where they are in their recovery journey</p>

<b>‘Doing hope’</b>
Setting and working towards goals
<p>Developing a positive ‘story’</p> <p>Identifying ‘role models’ or peers living well with similar mental health difficulties</p> <p>Finding times when things have gone well</p> <p>Pointing out and praising achievements (however small)</p>
Helping the client to imagine a different future
<p>Helping the client to take ownership of their care and well-being</p> <p>Encouraging involvement</p>

Category key:

Green	Holding on to hope
Pink	Doing reasonable hope
Yellow	Being the intervention
Blue	Emotional impact
Orange	Journeying with the person

6

## Appendix 13 Example of an early memo

### **Memo 7.9.14 A note on ‘dual relationships’**

‘We’re kind of in a funny place as staff in a secure ward, because, you know, I didn’t come into this job to be a prison officer and yet, sometimes that’s how we’re viewed. It’s getting that balance right’ (Participant 1, I 384 – 387)

‘I’ve always said I think a good forensic nurse is someone who can recognise, yes you need the security but it’s about working with the people as well, it’s about getting that nursing in there as well. So you kind of have to be, you have to balance it out’ (Participant 2, I 471 – 476)

‘It’s a bit difficult trying to understand that the people who are trying to build up a relationship with you and get trust when next thing, you’re going through their soaps and their personal belongings. I guess they feel invaded and it’s hard to try and strike that balance’ (Participant 2, I 482 – 486)

‘I think it’s quite evident if anyone goes on to the unit that staff have generally got a good relationship with patients and I think that’s almost like the relational security of the place keeps any incidents to a minimum’ (Participant 2, 341 – 344)’

The excerpts above seem to highlight the challenges for participants in balancing the therapeutic and security elements of their job. I wonder what specific impact this has on beliefs about hope and practices to try and instil hope – at this stage it seems that this can impact by making it more challenging for participants to maintain a strong therapeutic relationship with patients, which seems to be an important factor in developing hope. This could be an idea to flesh out in further interviews. However, I am also aware that, from my own experience and from previous reading, the idea of reconciling conflict in one’s mind between therapeutic and security aspects of the job or having a dual role, is one that I am interested in. I wonder then, whether this is something I have prompted participants to talk about (perhaps through a leading question or showing a particular interest when this area comes up) and I am wary of making the link between this and developing hope prematurely, without grounding it in the evidence. To guard against this, I think I need to read back over my interviews so far and ascertain whether this is an idea that participants have discussed spontaneously or whether it has been prompted by me in some way. It could also be helpful to discuss this within supervision, in order to explore whether my ideas are influencing my interviewing style. It may also be a topic to watch on for in future interviews, and to be aware whether I am ‘forcing’ this or whether it comes up naturally.

(My thinking around this memo was influenced by McGrath (2012) as cited in Charmaz, 2014).

Appendix 14 Memos demonstrating the development of the category 'Doing reasonable hope'

**Memo 28.1.15 Striving for progress**

Codes included:

- Identifying goals (1, 4, 6, 7, 8, 9)
- Setting clear, concrete goals/plans (1, 4, 6, 8)
- Maintaining a shared focus on future goals and moving forwards (1, 4)
- Making contingency plans (6, 7)
- Enjoying the process: setting and achieving goals (7)
  
- 'Taking baby steps': small steps towards goals (3, 4, 6, 7, 8, 9)
- Continually moving forwards (3, 7, 9)
- Feeling like progress, however slow, is being made (3)
  
- Identifying the impact of the context on hope: 'Small things can be very big things' (2, 3, 5, 8, 9)
- Appreciating the simple things: Seeing progress happening (3)
- Having a different level of hope (3, 4)
  
- Hope is: Having things to aspire to (2, 8, 9)
- Having things to look forward to/anticipation of something positive (4, 6, 7)
- Future oriented (1, 3, 4, 6)
- Having goals to work towards (3, 4)
- Believing things will change (3, 4)
- Motivating (3, 7, 8)
- Knowing what you aim for can be achieved (1)
- Avoiding despair (3)

*This category is about hope as being a future-focussed, motivating force. It brings together the way in which nurses' conceptualised hope and their beliefs about hope with the practices through which they identified that they helped service users to develop a sense of hope. Identifying long-term goals for the future, based on patients' values, dreams and aspirations, then breaking these goals down into smaller, shorter-term steps, was seen as hope-instilling. The focus was very much on moving forwards rather than standing still. However there were challenges to continual progress, particularly challenges specific to the secure setting – such as a patient's restriction or conviction impacting how they can progress, or sudden changes happening as a result of staff or regime changes. Working with uncertainty itself was highlighted as a negative influence on progress and on hope – the patient not knowing, for example, when they will be discharged. So far, these blocks or challenges to hope have grouped and will be*

*discussed individually. However the title 'striving for progress' reflects that progress may not always come easily. Should this title be 'striving for hope' rather than 'striving for progress'?*

*The different groups of codes above show that initially, several codes existed around identifying, setting and achieving goals. There were a number of codes about beliefs of hope as being future oriented, having things to look forward to or work towards:*

I: So it seems, from what you were saying it's about, maybe (p) having things perhaps you want to achieve or things for the future (p) it seemed like that was –

P: - (overlap) yeah it's like an eliciting word (end of overlap) about what they kind of want to achieve' (Participant 2, L17 – 21)

'Yeah I mean for me it's kind of (p) it's almost like a goal isn't it, or a target (pause) like a light at the end of the tunnel kind of thing (long pause) It's also obviously really important to have hope because if you don't have hope, (p) it's like a bottomless pit sort of thing' (Participant 3, L3 – 7)

I: One thing I was going to ask, coming on to that is (p) how hope is used, or not, in the work that you do?

P: Erm, I think it's really important. Cos again it gives (pause) (exhales) the patient targets or goals to aim for, but (pause) the patient or service user isn't just stuck in the system (pause) isn't just constantly day in, day out, erm (pause) the same routine (pause) I think erm, yeah the patients we work with we always have targets, goals erm (p) and it gives the patient hope as well, that things are going to get better, it's not always going to be as it is or as it has been in the past' (Participant 3, L27 – 36)

'I am quite a hopeful in the sense of ... I enjoy small things. I always goal set, I always make sure I've got things to look forward to. So I always try to be hopeful' (Participant 4, L5 – 9)

'I think it's almost like (pause) an energy that comes from (p) that, that you (p) you create yourself from an expectation that things are going to get better. And it gives you motivation - motivation is a better word than energy I think, that's been hijacked by sort of a New Age thinking, that energy word, but I think it can give you motivation that - (p) to keep going because things can get better' (Participant 5, L8 – 14)

'I think for me, about having hope, is what gets me up at quarter to seven this morning or whatever it was when the alarm went off. You hope that you can help someone, you know' (Participant 8, L49 – 51)

*These beliefs and conceptions of hope had an impact on how the nurses talked about instilling or developing hope with the patients they worked with. Setting and working towards goals was mentioned by a number of participants as a way to instil hope with service users. This was often done*

*in a collaborative way through the use of a recovery-based tool, such as the 'My Shared Pathway'. For example:*

'Over here we use the recovery – er sorry the Shared Care Pathway, which (p) is very patient focussed, you know it's about where are you, and where do you want to be? And how are we going to get you there? So that's sort of (p) really helpful, to kind of get people to really concentrate on what it is they want' (Participant 1, L125 – 130)

'But it's (p) reminding people, you know, 'if you do this and this and this, then you're on your way to rehab' (Participant 1, 322 – 324)

'Using ways, using motivational interviewing kind of ways, to get them to come to some of the conclusions about what they want for their futures, rather than telling them everything. They're more likely – if they've thought about it themselves – you sow all the seeds and then you see where, you know (p) what they want. And then ask them, how they think they can get there and maybe help them with suggestions' (Participant 4, L490 – 497)

'You know, the ABC analysis of it, this is what they should be doing, this is what we want them to do; the art of nursing is B, getting them through that' (Participant 8, L67 – 70)

P: 'I suppose here they've kind of hit rock bottom sometimes and it's (pause) putting that hope back into them where obviously, (as if speaking to a patient) 'You will get out', and try and look at goals with them to give them something to aim for, hopefully.

I: I just wondered if you could tell me a little more about things you do with the aim of instilling hope? If you can think of any examples of how you might do that?

P: Erm (pause) I suppose it's looking at like their short-term goals...' (Participant 9, L22 - 31)

*Other groups were based on the themes of making continual progress, no matter how small this progress was; the important thing for the nurse is to help the patient (and themselves) feel that the patient is moving forwards. This often equated to breaking bigger goals into smaller, more manageable steps:*

'Well I think you're moving forward, forward all the time aren't you, rather than being static' (Participant 3, L23 – 24)

'I always just think about starting little. You know, the little steps. Kind of like a long road and each step, is where they wanna be and each step's got a goal, rather than looking at the main goal cos it's too far away. And people will lose hope won't they?' (Participant 9, L490 – 494)

*The impact of context was also important here: nurses identified that in the secure setting, small things (such as eating a nice meal, going out for a walk, looking forward to an activity) are often seen as very significant to the patient*

*and should not be overlooked. They were often cited as small steps or achievements towards bigger goals (e.g. achieving grounds leave, moving to a rehabilitation ward on the unit).*

*'It's simple things as er, a patient's on the ward, they're doing well on the ward, we have no issues with them, their mental health seems reasonably stable, they get a bit of community ground's walk maybe, something as simple as that, that gives the person a bit of hope that thing's are happening, which (p) does happen as well, obviously (p) there's different wards, as you know [name of unit] is acute and we're rehab which is kind of the next level to [name of rehabilitation unit] so when a patient is even admitted on to this ward it gives them a bit of positivity that they're moving forwards slightly, so there's a bit of hope there' (Participant 3, L250 – 260)*

*'Now, that might seem very insignificant for us, you know, we can go the supermarket, get a takeaway, whatever, but for someone that's been in services for 2 years, has never actually had a meal outside of the hospital setting, was massive. And we worked to that – I think it was 3 months he was on our ward, 12 weeks of weekly one-to-ones' (Participant 8, 198 – 203)*

*This memo has links to several others. Nurses often discussed setting goals relating to the patient's journey or progress through the system and as such, the current memo has links to Journeying with the patient (see Memo 29.9.14 Being there through the journey).*

*Also, as mentioned initially, I need to consider whether some of the potential obstacles or challenges to making progress and moving forwards should be incorporated with this memo into a broader theme about progress (see memo Blocks to Hope).*

*Is hopelessness seen as 'giving up' and not progressing? If so, what impact does this have on how nurses' work with clients who are lacking hope? It may be that I am sensitive to this concept, as it has come up during recent reading I have done as part of my literature review - e.g. Russinova (1999) writes a great deal about the need for mental health practitioners to 'do' things with clients, rather than 'be' with them – in the face of hopelessness and despair this can often lead to working harder and trying to motivate the client more and more, ultimately leading to frustration on the practitioners' part. I am aware that it also came up in previous research (Vass, 2011b). However there does seem to be a significant focus on the future and working forwards towards goals in the beliefs and practices of the nurses interviewed so far. I think it would be helpful to go back and look at any times when participants have spoken about patient hopelessness or despair: how have they managed this? I am also not happy that the title of this code quite captures it.*



### **Update 9.2.15**

*During a GT supervision meeting on the 5.2.15 I shared a tentative framework of emerging categories and some links between them (see also Memo 31.1.15 Strong therapeutic relationship, update 7.2.15). I shared the ideas outlined in this memo, and discussed participants' conceptualisation of hope as an active and motivating process. I discussed the link between this conceptualisation and participants' instilling hope for the future by setting and working towards goals. This discussion raised some interesting points:*

- *What is the difference between the codes 'success stories' and 'drawing on the evidence'?*
- *Is there an opposing theme to that of hope as goal and progress oriented? HC described this as the 'ying-yang' of categories. Opposing yet complementary processes? Variation across a category? Does the therapeutic relationship, embodied hope or 'attuning to the client' represent this other side of this theme? (This is discussed further in the Memo 31.1.15 Strong therapeutic relationship, update 7.2.15)*
- *What impact (if any) does the medium secure setting have on the nurses' focus on progressing the client through the system?*

*Following this meeting I returned to the focussed codes and memos whilst holding these ideas in mind. 'Doing hope' emerged as a category from grouping codes, resulting in several categories:*

- *Identifying and achieving goals*
- *'Taking baby steps': appreciating small gains*
- *'Hope feeding hope': building momentum*
- *Developing a different imagined future*
- *Having a positive stories/narratives*
- *Choice and control*
- *Personal responsibility*
- *Realistic hope*

*'Doing hope' is based on the conceptualisation of hope as future-oriented and motivating:*

*'I: So it seems, from what you were saying it's about, maybe (p) having things perhaps you want to achieve or things for the future (p) it seemed like that was –*

*P: - (overlap) yeah it's like an eliciting word (end of overlap) about what they kind of want to achieve' (Participant 2, L17 – 21)*

*'Yeah I mean for me it's kind of (p) it's almost like a goal isn't it, or a target (pause) like a light at the end of the tunnel kind of thing (long pause) It's also obviously really important to have hope because if you don't have hope, (p) it's like a bottomless pit sort of thing' (Participant 3, L3 – 7)*



'I think it's almost like (pause) an energy that comes from (p) that, that you (p) you create yourself from an expectation that things are going to get better. And it gives you motivation - motivation is a better word than energy I think, that's been hijacked by sort of a New Age thinking, that energy word, but I think it can give you motivation that - (p) to keep going because things can get better' (Participant 5, L8 – 14)

'I think for me, about having hope, is what gets me up at quarter to seven this morning or whatever it was when the alarm went off. You hope that you can help someone, you know' (Participant 8, L49 – 51)

*Nurses work actively with clients to build hope by making progress towards recovery. Hope is seen as an evolving process, building momentum as the client notices change.*

'They will see the benefits of [engaging with treatment] and be more inclined to tell other people 'Well actually, I thought the same as you but (p) it's worked'' (Participant 6, L400 – 402)

'Supporting people to find solutions to the next stage, is what it's all about' (Participant 7, L110 – 111)

*Nurses 'do hope' through employing several practices and strategies. Setting and working towards shared goals was seen as important:*

'I: One thing I was going to ask, coming on to that is (p) how hope is used, or not, in the work that you do?

P: Erm, I think it's really important. Cos again it gives (pause) (exhales) the patient targets or goals to aim for, but (pause) the patient or service user isn't just stuck in the system (pause) isn't just constantly day in, day out, erm (pause) the same routine (pause) I think erm, yeah the patients we work with we always have targets, goals erm (p) and it gives the patient hope as well, that things are going to get better, it's not always going to be as it is or as it has been in the past' (Participant 3, L27 – 36)

'Over here we use the recovery – er sorry the Shared Care Pathway, which (p) is very patient focussed, you know it's about where are you, and where do you want to be? And how are we going to get you there? So that's sort of (p) really helpful, to kind of get people to really concentrate on what it is they want' (Participant 1, L125 – 130)

*Goals were often linked to progress through the unit:*

'But it's (p) reminding people, you know, 'if you do this and this and this, then you're on your way to rehab' (Participant 1, L322 – 324)

'If you talked to most people (p) patients on the acute assessment unit, if you said to them for example 'where do you want to be in 6 months time?' they'd say 'Oh I'd like to be on [name of rehabilitation ward] I'd like to be on the

rehabilitation unit' and that's their hope at the time, moving forward' (Participant 2, L569 – 574)

'It's simple things as er, a patient's on the ward, they're doing well on the ward, we have no issues with them, their mental health seems reasonably stable, they get a bit of community ground's walk maybe, something as simple as that, that gives the person a bit of hope that thing's are happening, which (p) does happen as well, obviously (p) there's different wards, as you know [name of unit] is acute and we're rehab which is kind of the next level to [name of rehabilitation unit] so when a patient is even admitted on to this ward it gives them a bit of positivity that they're moving forwards slightly, so there's a bit of hope there' (Participant 3, L250 – 260)

*Nurses identified that progress could be limited by factors outside of the nurse and client's control (for example: restrictions enforced by the section under which the client is under; sudden or unexpected changes to the unit regime e.g. limited resources, staffing turnover; public perceptions and pressure from 'higher powers', which was noted to increase concerns about risk).*

'It feels to [the service users], I imagine, that they're a lot more restricted than someone who is under a normal section or on a normal mental health ward. And also the process is A LOT slower (pause) a lot, lot slower, because even if someone's on a hospital order there's a lot more risk taking involved, positive risk taking' (Participant 4, L517 – 519)

'Sometimes when activities get cancelled, you know, through nobody's fault, if someone's not well and they phone in sick, that's demoralising for patients' (Participant 5, L633 – 635)

'One of the goals could be to be discharged, but they're on some sort of weird sentence where it means that's never going to happen for like 10 years, so it's thinking what else can we do?' (Participant 6, L115 – 118)

'Whereas a section is until you're deemed safe to yourself and to others, so (p) keeping that hope in saying 'Yes, you can do this' – you know, you talk about SMART [goals]' (Participant 8, L80 – 82)

*Many nurses therefore emphasised the importance of breaking down goals into smaller steps and acknowledging small achievements.*

'Now, that might seem very insignificant for us, you know, we can go the supermarket, get a takeaway, whatever, but for someone that's been in services for 2 years, has never actually had a meal outside of the hospital setting, was massive. And we worked to that – I think it was 3 months he was on our ward, 12 weeks of weekly one-to-ones' (Participant 8, L198 – 203)

'I always just think about starting little. You know, the little steps. Kind of like a long road and each step, is where they wanna be and each step's got a

goal, rather than looking at the main goal cos it's too far away. And people will lose hope won't they?' (Participant 9, L490 – 494)

*Perhaps this is also why hope was often marked against external measures of progress (such as level of security and restriction within the unit)? Does this provide a concrete and tangible measure of hope, which may otherwise be difficult to gauge?*

*In 'doing hope' the nurse also aims to give back choice and control to the service user. Nurses noted the significant limitations on service users' choice. This was often noted through reference to the client not being able to make the most basic of choices autonomously (e.g. making a cup of tea).*

'They've had all that stripped away, it's almost like a process of infantilising them, and all they've got is these little things' (Participant 5, L503 – 505)

*The nurses attempted to give back choice and control by encouraging clients to take an active part in their own care (for instance attending care planning meetings, identifying goals, learning about medication and treatment options). The nurses also emphasised the importance of allowing clients to make unwise choices (choices that were not seen as deal or as having some negative consequences for the client BUT when the client has capacity to make decisions for themselves).*

'They (p) have a lot of choice taken away from them but (p) they still have choices' (Participant 7, L36 – 37)

'People need to be allowed to make mistakes, to give them a reason to do anything' (Participant 7, L458 – 460)

'If a patient wants to go and spend 100 quid on a pair of jeans, I've had big fall-outs with TEAMS where, that's their choice' (Participant 8, L800 – 803)

*In giving back choice and control, nurses talked of encouraging clients to take personal responsibility for their own recovery:*

'You've got no ambition if you've got no hope, you just think 'well this is my lot, nothing I can do about it' kind of in our setting, you become, sort of (p), I use this term professional patient' (Participant 1, L88 – 91)

'We try to get people involved in their care as much as we can. You know, 'get into your multi-disciplinary meeting, listen to what people are saying about you, what the plans are, tell them, tell the team what it is you want ... Don't just sit back and let it all be done to you' (Participant 1, L335 – 342)

'P: You do tend to feel that he's, he's obviously not in the right place. Do you know what I mean? In himself, and perhaps with us as well, because he's not moving on.

I: What do you think that's about for him?

P: I think it's about his environment and again, not taking responsibility. There's something in him that doesn't want to be (p) in the community' (Participant 4, L319 – 325)

'If you can get them to discuss some of these issues it gives them that bit of hope that maybe this won't occur again, or 'how can I stop myself from carrying out these kinds of behaviours or erm (p) preventing a relapse?' (Participant 3, L450 – 454)

*In 'doing hope' the nurse also aims to offer a different perspective to the client and open up space to consider different possibilities and options for the future.*

'Promoting that they can do better, and they can get out of services or they can be part of services back in the community WHERE THEY WANT TO BE' (Participant 8, L115 – 117)

'You talk about instilling hope, (p) making a patient believe that they can do better for themselves is what its about' (Participant 8, L645 – 647)

*The nurse offers the opportunity for a positive narrative or story. For example, by identifying positive 'role models' – other people living well with mental health difficulties. These role models could be celebrities or other peers further along the recovery process. The important thing seemed to be finding someone who the client could relate to.*

'When you see someone who (p) to all extents and purposes is successful, is famous, is on the telly, you can say, 'Look. You see that person there? You've heard of them, this person, yeah? Well they suffer with the same thing that you do' (p) and it's kind of a physical reminder of 'look what can be achieved' (Participant 1, L166 – 172)

'Sometimes you'll give (p) like obviously anonymised examples of positive experiences that other people have had, things have seemed hopeless at the time but actually they weren't, and there was a good outcome eventually' (Participant 5, L117 – 120)

'But if they hear about someone having a positive outcome because they've put the effort in (p) it helps them to see that 'Well, that person's like me, and that person did that, and then things got better'. If you can get them to identify, you know choose an example that's appropriate that that person can help to identify with, I think that can be quite helpful. I think most of us do that so (p) like 'I knew this lad once that blah blah, he had a similar problem to you, and we did this and he did that, he had, we had a few slip-ups but eventually that happened'' (Participant 5, L262 – 272)

'I guess (pause) probably (pause) picking up on who the sort of positive patients are as well and it's sort of raising their profiles on the ward and hoping that then, the more challenging patients will become sort of more therapeutically aligned' (Participant 6, L326 – 331)

*However, the stigma about mental health difficulties present in the media and within services was identified as a challenge to hope:*

'It's always the negatives, so you know, the general public who probably don't have any contact with mental health services could see it in a very negative light (p) and so could people who are suffering' (Participant 1, L198 – 201)

'And she was incredibly stigmatised, which is when people say that someone is 'well known to services', I hate that, because it's a way of service's stigmatising and labelling the person' (Participant 5, L414 – 417)

'I'm sick to death of reading a paper about a schizophrenic that's (adopts derogatory tone) oh, done this and that. Well, what about the 10 million schizophrenics who are living and coping and doing really well?' (Participant 8, L647 – 651)

*'Doing hope' is about moving forward, opening up possibilities, raising the client's sense of autonomy and self-belief. However a modifier here seems to be the need to temper unrealistic hopes. Further reading has helped to develop my ideas around the theme of realistic hope, which may be better categorised as reasonable hope (in line with Weingarten, 2010). Although labelled 'realistic hope' nurses' seemed uncomfortable with the idea of naming a client's hope as 'unrealistic' perhaps because of the moral judgement carried or the risk of destroying hope:*

'I think (p) it's about (pause) with clients (p) patients, or whatever we're calling them this week sort of (p) helping them to see (p) that this isn't (pause) all of sort of all they can expect from their life, being in hospital, being ill erm (pause) letting them know (p) that they can progress and they can feel better. Erm. And achieve things that they want to achieve. But with a kind of (p) sometimes there's a kind of caveat isn't there, and it's like, people might have unrealistic hopes and dreams for themselves that, you know, realistically probably won't happen but you can kind of (p) steer them in the same direction – ' (Participant 1, L15 – 25)

'But not ruling anything out but saying, 'OK, maybe we won't get you there but how about this?' (Participant 1, L61- 62)

'And even though you're trying to instil hope, you don't want that to be unrealistic as well. It's making people have the small steps first, erm, because you don't want people to give up, aim too high and then give up' (Participant 2, L 46 – 49)

'It's being realistic (p) If you're going to be unrealistic and making promises you'll destroy hope because it leads people to be disappointed, it sets people up to fail' (Participant 5, L 134 – 137)

*Reasonable hope is about the nurse working to develop a shared perspective or agenda with the client and bringing together potentially differing views in order to identify workable goals – guarding against both trampling and destructing a client’s fragile sense of hope whilst avoiding the pull to agree with goals that the client is unlikely to reach. As Weingarten states:*

*‘Reasonable hope, consistent with the meaning of the modifier, suggests something both sensible and moderate, directing our attention to what is within reach more than what may be desired but unattainable’ (2010, p7).*

*What do I need to know?*

*In ‘Doing hope’ is there is an accepted belief that the client will know the answers to the questions about their own future?*

*‘Over here we use the recovery – er sorry the Shared Care Pathway, which (p) is very patient focussed, you know it’s about where are you, and where do you want to be? And how are we going to get you there? So that’s sort of (p) really helpful, to kind of get people to really concentrate on what it is they want’ (Participant 1, L125 – 130)*

*What if the client is unable to imagine a different future? To formulate a response to these questions - which involves very high level, abstract reasoning and decision-making, along with the language abilities to communicate a response and a degree of self-confidence to do so? Given the high proportion of individuals in the criminal justice system who experience cognitive and learning difficulties (as cited within the research literature) how many service users will find this difficult?*

*If the client is not seen as taking personal responsibility for his own mental health difficulties and behaviour, what impact does this have on the nurse holding on to the hope? Is there something here about the nurse externalising or attributing the difficulties in developing hope on to the patient?*

*How does developing hope as a team link to ‘doing hope’? Is this a property of ‘doing hope’ or a separate category?*

#### **Note 14.2.15**

*What is the relationship between the nurse’s level of hope and the practices they use to develop hope? For example, does a greater emotional impact or loss of hope lead to a more task-oriented focus? Does this result in less of a focus on ‘being the intervention’ and the therapeutic relationship? Is this necessary in order for the nurse to re-gain his or her own sense of hope? Are there any risks to the client’s hope of becoming too task-oriented? For example:*

*‘You can get bogged down in, I’m going to say paperwork, because everybody will say that, you can get bogged down in that, and procedures*

and admin, but sometimes you know, you have to try and brush all that away and do this elusive thing about instilling hope' (Participant 5, 200 – 205)

#### **Note 22.2.15**

*I plan to check out the tentative categories of 'Being hope' and 'Doing hope' with a participant. Following supervision with SN I consider the best way in which to share these ideas for feedback. I want to check out ideas yet remain open to the participant's views and experiences. I have adapted the interview schedule (see version 6) in order to do so, incorporating a table with some of the codes in the categories 'being the intervention' and 'doing hope'. I am particularly interested in finding out how the participants conceptualises links between these two categories, and what may influence them to focus their work in either area in particular.*

#### **Update 26.2.15**

*Following peer supervision with SN and interview with participant 10. I have developed the category of 'doing hope' and re-labelled it as 'doing reasonable hope'. 'Reasonable hope' encompasses participant 10's reluctance to label a hope as 'realistic' in order to guard against dashing a person's fragile sense of hope. This fits with what other participants have said and reflects the nurses' wariness of labelling hopes as 'unrealistic'. 'Reasonable hope' reflects the nature of ensuring that hopes are workable and achievable, it is a pragmatic attempt to sustain hope and negate disappointment and loss rather than a moral judgement.*

#### **Definition**

'Doing reasonable hope' reflects the more goal-oriented work that the nurse sees as inspiring hope in the person they work with. This work is focussed on the future and on making progress. It is about offering different options and opening up possibilities, and collaboratively developing the means through which to achieve them (participant 8 likens this to providing the person with 'tools' for their 'toolbox'). There are links here to cognitive models of hope (such as Snyder's pathway model). Doing 'reasonable' hope represents the balance evident in the data, between the nurse maintaining a potentially fragile sense of hope whilst also guarding against the inevitable disappointment and loss in going along with unmanageable or unattainable expectations. 'Reasonable hope' represents a merging of the nurse and the client's perspectives and agendas, rather than the nurse imposing hope on to the client. The nurse sees work in this area as developing hope through helping the person to develop a more positive story or narrative and through helping the person to take ownership or responsibility for their own care and well-being.

#### **Contributing codes:**

Identifying goals (1, 4, 6, 7, 8, 9, 10)

Setting clear, concrete goals/plans (1, 4, 6, 8)

Developing a concrete plan (1)

Developing a shared sense of moving forwards (1)

Knowing what can be achieved (1)

Maintaining a shared focus on future goals (4)

Making contingency plans (6, 7)

Enjoying the process: setting and achieving goals (7)

'Taking baby steps': small steps towards goals (3, 4, 6, 7, 8, 9)

Continually moving forwards (3, 7, 9)

Feeling like progress, however slow, is being made (3)

Appreciating the simple things: Seeing progress happening (3)

Having a different level of hope (3, 4)

'Hope feeds hope: building momentum' (4, 5, 6, 7, 9)

Empowering the client (1, 3, 4, 10)

Developing the person's sense of agency and control (7, 10)

Helping the person to have a voice (1)

Providing a voice to those with mental health difficulties (1, 6)

Allowing for mistakes and unhelpful choices (7, 8, 10)

Giving back independence (3)

Giving personal responsibility (4, 8, 10)

Developing insight – helping person to manage own mental health (3, 8, 9, 10)

Developing person's ownership of hope and recovery (6)

Encouraging active involvement in care (1, 3, 8)

Developing a different imagined future (1, 3, 4, 7, 8, 10)

Developing a shared future vision (1, 6, 7, 10)

Offering a different perspective (4, 7, 8)

Emphasising the possibility for change (3)

Giving possibilities (1, 4)

'It's not always going to be like this': Giving options (1, 3, 4, 5, 8, 10)

Broadening horizons (1, 3)

Helping the person to develop insight into valuable opportunities (2)

Having a positive narrative/story (1)

Identifying people living well with mental health diagnosis (1)

Embodying hope (role models) (1, 2, 4, 5, 6, 7, 8)

Focussing on the positives (1, 7, 8, 9, 10)

Giving positive praise (4, 7)

Building positive mental health and self-esteem (4, 5)

Reinforcing self-belief (1)

Instilling realistic hope (1, 3, 4, 5, 6, 7, 8, 9)

Merging staff-service user expectations (6, 8, 9)

Developing a shared understanding of hope – between other staff and with the service user (2, 7, 9)

Guarding against dashed hopes (9, 10)

Helping to manage disappointment (4, 7)

Never denying hope (no matter how unrealistic) (1, 7, 9, 10)

Making a culturally relevant judgement about realistic hope (6)

Hope is something that could realistically happen (1)

Acknowledging harsh realities (3)

Imposing hope (1, 4, 6, 8, 9)



**Grouped focussed codes:**

Setting goals

Focus on progress

Empowering the person: responsibility, control, choice

Developing a positive story

Developing a different imagined future

Reasonable hope

**Modifiers/variance in this category****Links to other categories**

- Coping with the emotional impact of the work
- There is variance across the category in terms of 'reasonable' hope – one participant was clearer that there was a need to acknowledge the 'harsh realities' of the person's situation, whilst participant 10 rejected the idea of tempering 'realistic' hope – was this modified by their acknowledged lack of experience of working with a person who they felt had unrealistic hopes?
- 'Doing hope' links to managing the 'emotional impact' of the work: the nurse is able to remind themselves of the person's autonomy (taking responsibility and ownership; recognising the limits of their own support). Another is for the nurse to remain focussed on the positives.

## Appendix 15 Photos demonstrating focussed coding (9.11.2014)



## Appendix 16 Photos demonstrating focussed coding (16.11.2014)





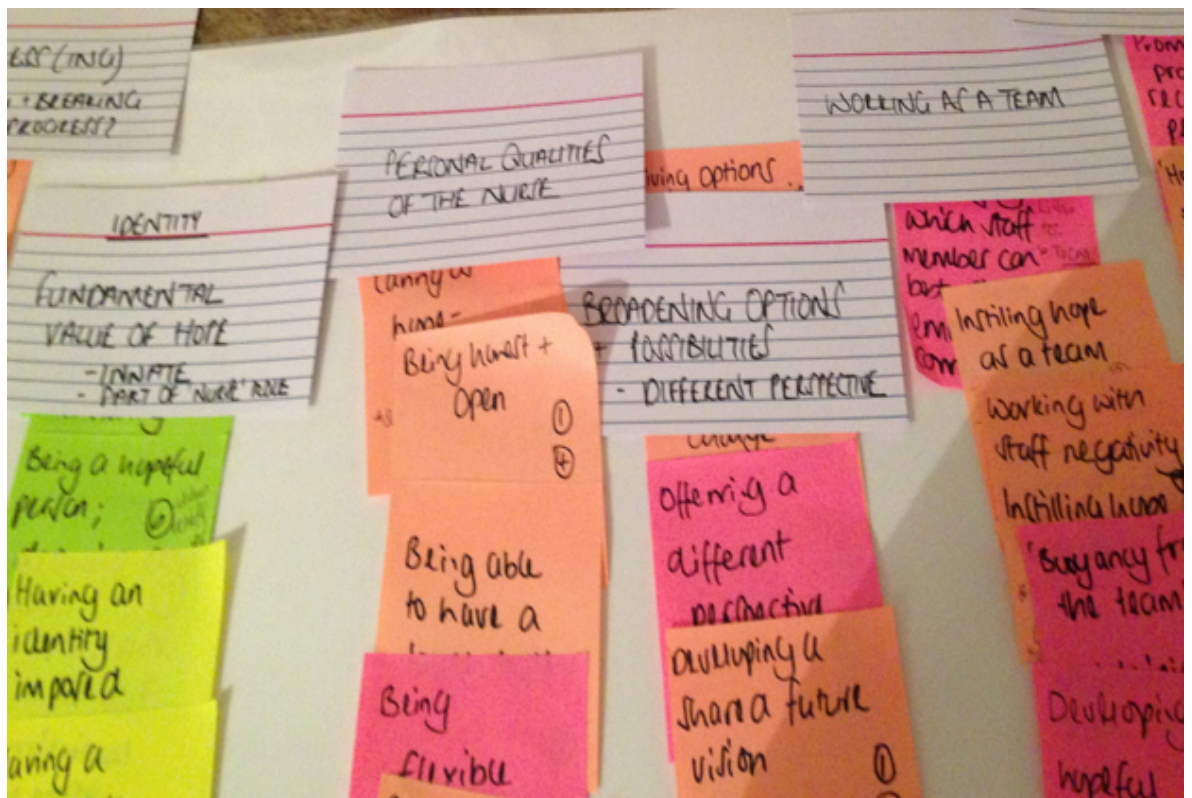
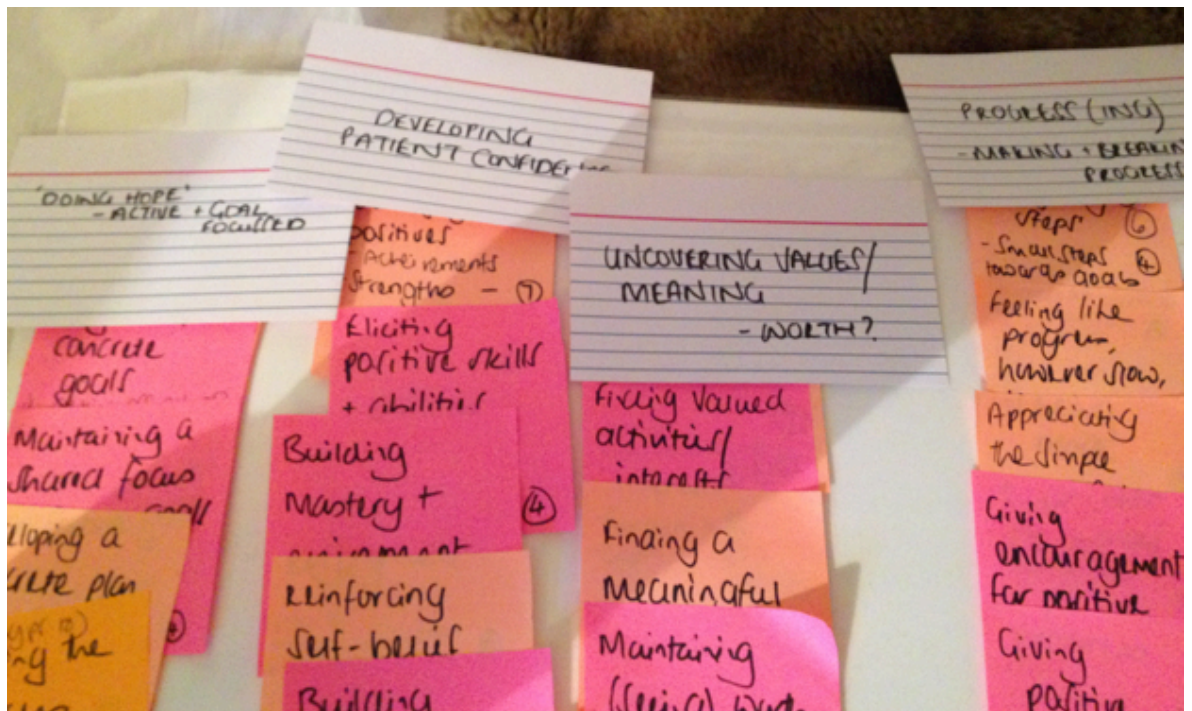
The image shows a large sheet of paper covered with numerous colorful sticky notes, each containing a handwritten definition of a different type of thinking. The notes are organized into columns and rows, with some notes having small circles or symbols next to them. The definitions cover a wide range of cognitive processes, from basic perception to complex problem-solving and critical thinking.

Some of the definitions visible on the sticky notes include:

- Perception:** The process of receiving information from the environment through the senses.
- Attention:** The process of focusing on a specific object or task.
- Memory:** The process of storing and retrieving information.
- Reasoning:** The process of using logic to solve problems.
- Problem-solving:** The process of finding a solution to a problem.
- Critical thinking:** The process of analyzing information and making a judgment.
- Decision-making:** The process of choosing between two or more options.
- Communication:** The process of sharing information with others.
- Collaboration:** The process of working together to achieve a common goal.
- Leadership:** The process of guiding and motivating others.
- Teamwork:** The process of working together to achieve a common goal.
- Conflict resolution:** The process of resolving disagreements.
- Emotional intelligence:** The ability to understand and manage emotions.
- Self-awareness:** The ability to understand one's own emotions and behaviors.
- Empathy:** The ability to understand and share the feelings of others.
- Resilience:** The ability to bounce back from adversity.
- Growth mindset:** The belief that abilities can be developed through effort.
- Fixed mindset:** The belief that abilities are innate and cannot be changed.
- Positive psychology:** The study of the factors that contribute to human well-being.
- Behavioral psychology:** The study of the relationship between behavior and the environment.
- Cognitive psychology:** The study of the mind and how it processes information.
- Developmental psychology:** The study of how people change and grow over time.
- Health psychology:** The study of the relationship between health and behavior.
- Environmental psychology:** The study of the relationship between the environment and human behavior.
- Social psychology:** The study of how people's behavior is influenced by others.
- Personality psychology:** The study of individual differences in behavior.
- Abnormal psychology:** The study of mental disorders.
- Biological psychology:** The study of the biological basis of behavior.
- Evolutionary psychology:** The study of how evolution has shaped human behavior.
- Neuropsychology:** The study of the relationship between the brain and behavior.
- Clinical psychology:** The study of the assessment and treatment of mental disorders.
- Counseling psychology:** The study of the process of helping people.
- Healthcare psychology:** The study of the relationship between psychology and healthcare.
- Forensic psychology:** The study of the application of psychology to the legal system.
- Industrial-organizational psychology:** The study of the application of psychology to the workplace.
- Public health psychology:** The study of the application of psychology to public health.
- Community psychology:** The study of the relationship between individuals and their communities.
- Environmental health psychology:** The study of the relationship between the environment and human health.
- Health communication:** The study of how to communicate health information effectively.
- Health behavior:** The study of the factors that influence health-related behaviors.
- Health equity:** The goal of ensuring that everyone has the opportunity to achieve good health.
- Health justice:** The goal of ensuring that everyone has the resources they need to achieve good health.
- Health systems research:** The study of how to improve the delivery of healthcare.
- Implementation science:** The study of how to put research into practice.
- Behavior change:** The process of changing one's behavior.
- Health promotion:** The process of enabling people to increase control over their health.
- Disease prevention:** The process of preventing the onset of a disease.
- Early detection:** The process of identifying a disease at an early stage.
- Screening:** The process of testing for a disease in people who do not have symptoms.
- Diagnosis:** The process of identifying a disease.
- Treatment:** The process of using interventions to improve health.
- Prevention:** The process of preventing the onset of a disease.
- Recovery:** The process of returning to a state of good health.
- Remission:** The process of a disease disappearing.
- Relapse:** The process of a disease returning.
- Prognosis:** The prediction of the outcome of a disease.
- Quality of life:** The overall well-being of a person.
- Health-related quality of life:** The quality of life related to health.
- Functional status:** The ability to perform daily activities.
- Physical function:** The ability to perform physical activities.
- Mental function:** The ability to perform mental activities.
- Social function:** The ability to interact with others.
- Emotional function:** The ability to manage emotions.
- Cognitive function:** The ability to think and learn.
- Motor function:** The ability to move the body.
- Sensory function:** The ability to receive information from the environment.
- Immune function:** The ability to fight off infections.
- Endocrine function:** The ability to produce hormones.
- Reproductive function:** The ability to reproduce.
- Developmental function:** The ability to grow and develop.
- Adaptive function:** The ability to adapt to the environment.
- Homeostatic function:** The ability to maintain a stable internal environment.
- Regulatory function:** The ability to control the body's processes.
- Integrative function:** The ability to bring together information from different sources.
- Executive function:** The ability to plan and execute tasks.
- Working memory:** The ability to hold information in mind for a short period.
- Long-term memory:** The ability to store information for a long period.
- Retrieval:** The process of getting information out of memory.
- Encoding:** The process of putting information into memory.
- Storage:** The process of keeping information in memory.
- Forgetting:** The process of losing information from memory.
- Amnesia:** The loss of memory.
- Alzheimer's disease:** A type of dementia characterized by memory loss.
- Parkinson's disease:** A type of movement disorder characterized by tremors.
- Huntington's disease:** A type of genetic disorder characterized by involuntary movements.
- Tourette syndrome:** A type of neurological disorder characterized by tics.
- Obsessive-compulsive disorder:** A type of anxiety disorder characterized by obsessions and compulsions.
- Major depressive disorder:** A type of mood disorder characterized by persistent sadness.
- Generalized anxiety disorder:** A type of anxiety disorder characterized by excessive worry.
- Bipolar disorder:** A type of mood disorder characterized by episodes of mania and depression.
- Schizophrenia:** A type of psychotic disorder characterized by hallucinations and delusions.
- Personality disorders:** A group of disorders characterized by rigid and inflexible patterns of thinking, feeling, and behaving.
- Eating disorders:** A group of disorders characterized by abnormal eating habits.
- Substance use disorders:** A group of disorders characterized by the misuse of drugs or alcohol.
- Self-harm:** The act of causing harm to oneself.
- Suicidal thoughts:** Thoughts of harming or killing oneself.
- Suicide:** The act of killing oneself.
- Mental health:** The state of the mind and emotions.
- Physical health:** The state of the body.
- Overall health:** The state of the entire person.
- Well-being:** The state of being happy and healthy.
- Quality of life:** The overall well-being of a person.
- Health and well-being:** The state of being healthy and happy.
- Healthcare:** The system of organizations and people that provide medical services.
- Medical care:** The treatment of a disease or injury.
- Public health:** The study of the distribution and determinants of health and disease.
- Global health:** The study of the health of the world's population.
- International health:** The study of the health of different countries.
- Community health:** The study of the health of a specific community.
- Population health:** The study of the health of a group of people.
- Health equity:** The goal of ensuring that everyone has the opportunity to achieve good health.
- Health justice:** The goal of ensuring that everyone has the resources they need to achieve good health.
- Health systems research:** The study of how to improve the delivery of healthcare.
- Implementation science:** The study of how to put research into practice.
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- Functional status:** The ability to perform daily activities.
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- Mental function:** The ability to perform mental activities.
- Social function:** The ability to interact with others.
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- Cognitive function:** The ability to think and learn.
- Motor function:** The ability to move the body.
- Sensory function:** The ability to receive information from the environment.
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- Endocrine function:** The ability to produce hormones.
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- Overall health:** The state of the entire person.
- Well-being:** The state of being happy and healthy.
- Quality of life:** The overall well-being of a person.
- Health and well-being:** The state of being healthy and happy.
- Healthcare:** The system of organizations and people that provide medical services.
- Medical care:** The treatment of a disease or injury.
- Public health:** The study of the distribution and determinants of health and disease.
- Global health:** The study of the health of the world's population.
- International health:** The study of the health of different countries.
- Community health:** The study of the



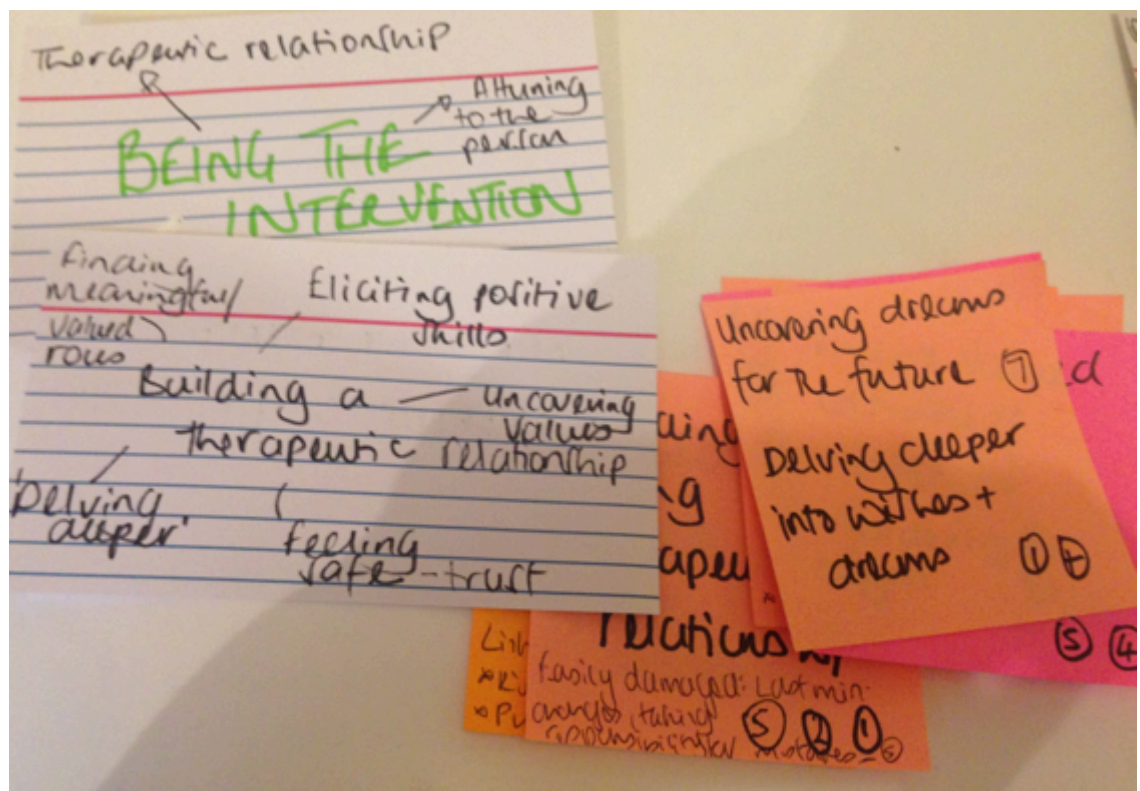
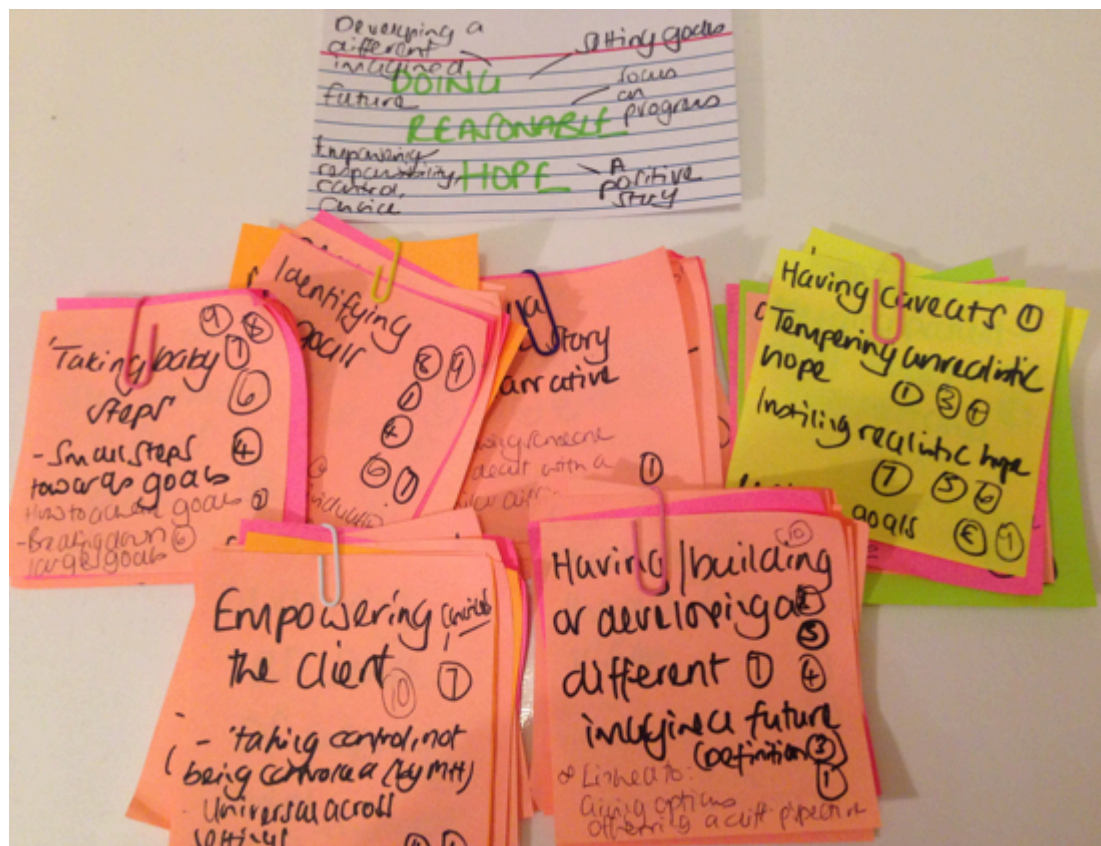




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Appendix 20 Examples of the development of two categories, *Doing reasonable hope* and *Being the intervention* (26.2.2015)



### **Paper 3**

#### **A Hope Full Thesis: Personal and Critical Reflections of Conducting a Grounded Theory Study Exploring Mental Health Nurses' Beliefs About Hope and Experiences of Fostering Service Users' Hope Within a Secure Setting**

This paper is not intended for publication.

**Word count:** 3,654



## **Introduction**

This paper outlines my reflections on the research process. I have chosen to structure my reflections around three of the main categories that emerged from data analysis within the empirical study (see Paper 2). The overarching influence of my prior experiences and beliefs on the development of the research question and analytic process are discussed initially. 'Being with participants' provides a reflexive analysis of the interview process whilst 'Doing the research' outlines a methodological critique of the research. The final section of this report describes the impact that the research had on my personal and professional values, along with the implications for my future clinical practice.

### **Beliefs about Hope: My Position Within the Research**

Elliott, Fischer and Rennie (1999) state that it is important for qualitative researchers to 'own' their perspective and position themselves within the research. They propose that being explicit about personal values and assumptions helps the reader to understand the role that these played in the research and to interpret the resulting analysis.

My previous experience of studying and working across the Prison Service initially sparked my interest in conducting research within forensic mental health settings. My previous experience revealed that in general, a limited amount of research has been conducted within such services (Coffey, 2006). I developed an interest in how individual staff and teams work in these settings, which to me often felt quite far removed from other 'mainstream' mental health settings. During my clinical training I also developed an interest in the concept of recovery. An on-going enthusiasm for clinical work in forensic settings meant that I was particularly eager to explore the concept of '*secure recovery*' (Drennan & Alred, 2012).

Initial discussions with my research supervisor began to narrow my scope from the broad area of recovery to the specific elements of the recovery model. These areas of interest converged on reading the paper by Vass (2011) who explored the views of service users in a forensic setting

about hope and optimism. Vass (2011) highlighted the need to explore how staff within these settings collaborate and develop hope with their clients. An initial scope of the literature and the subsequent review (see Paper 1) clarified that little previous research existed in this area.

To ensure a strong research design, researchers must choose a research paradigm that is congruent with their beliefs about the nature of reality (Mills, Bonner & Francis, 2006). When developing my research question and study design I therefore subjected my beliefs to an '*ontological interrogation*' (Mills et al., 2006). In line with Birks and Mills (2011) early in the process I utilised my research journal to consider my own epistemological position. Social constructionists deny the existence of an objective reality and assert that realities are '*social constructions of the mind*' (Guba & Lincoln, 1989, p.43). Excerpts from my journal in which I considered my own beliefs about knowledge, truth and reality show that my stance within the research reflected a social constructionist position:

*"We define ourselves by our place in the world, our standing in relation to others and by our roles within life ... which may change throughout our lives, depending on the context we are in. Reality is something we shape and share together ... Researcher and participant may influence each other through their own beliefs and position..."*

Entries within the journal also provide examples of questions that one of my research supervisors encouraged me to consider at an early stage: "*What do you want the outcome of your research to be?*" and "*Are you interested in personal experiences or relationships?*" My interest in developing a theory of the way in which staff foster hope with service users and my belief that hope is experienced in the context of a relationship with another (see also Farran, Herth & Popovich, 1995) led me to Grounded Theory (GT) and in particular, Charmaz's social constructionist approach (see Charmaz, 2014).

Throughout the research I questioned my beliefs about hope in light of my epistemological position. Initially I framed my research title as: *Instilling hope within a forensic mental health setting: A Grounded Theory of staff beliefs and practices*. However part-way through the interview and analysis process I considered the implications of the term 'instilling' hope. Such language reflects a more positivist position of hope as an objective construct that can be 'given' from one person to another. McCann (2002) posits that hope cannot be instilled but must be uncovered, supported or reinforced. Following the third research interview I attempted to remain more open to the meaning that participants' ascribed to hope and conceptualisations that developed through the interview process. For example, I employed more neutral terms such as 'foster' hope. Whilst even this term assumes that hope is something that can be developed between two people I believe it was easier for participants to make their own interpretations. However, it is acknowledged that the title may have influenced the way in which participants spoke about hope within the research interview. In addition I also found examples within later transcripts of times that I had slipped back to more positivist language.

### **'Being With' Participants**

In conducting the research interviews I aimed to understand and represent the experiences and actions of participants as they encountered, engaged and lived through situations (Elliott et al., 1999). DiCicco-Bloom and Crabtree (2006) discuss the importance of developing a rapport with research interviewees, to gain richer and more meaningful data. The process of developing rapport and trust with the interviewee in a short space of time reflected some of the skills nurses' employed to develop a therapeutic relationship with the service users they engaged with. Initially I believed that my therapeutic skills would stand me in good stead to engage with participants and draw out their personal experiences. However, I experienced some unexpected challenges from which I learnt a great deal.

Madill and Gough (2008) suggest that researchers conducting semi-structured interviews should strike a balance between interviewer control and

approximating normal conversation. An excerpt from my research journal following the first three research interviews reflects the struggle I encountered in maintaining this balance:

*“I thought, going into the research, that I would just feel equal to my research participants and the discussion would be a collaborative one. I was surprised to find that participants seemed very nervous about their responses and seemed to want to get things ‘right’. I reflected whether participants perceived me as having some power or control in the situation. It felt like that, and I felt uncomfortable about it...”*

On further reflection and through discussion with my research supervisor and other members of staff at the research site I considered a number of factors that may have influenced the perceived power imbalance. I became aware that nursing staff at the research site had fairly recently engaged in training about the recovery model. I therefore wondered whether participants felt that they were being ‘tested’ on their knowledge, which created some anxiety. I noted that participants appeared wary of being seen as critical of the model (or going against “*the company line*”), which may have detracted from their openness at times. It is recognised that this is a limitation of the interview methodology. The first three participants also commented specifically on the difficulties in defining the term ‘hope’, which could have led to feeling nervous.

Importantly I also considered the influence of my own interview style, particularly after one participant commented that it felt like he was being interviewed for a job! Yardley (2000) discusses the concept of ‘*commitment*’ in qualitative research, which includes the development of competency and skill in the methods used. I reflected that my previous lack of research interview experience may have increased my own level of anxiety. On listening to the research interviews I noted that some of my questions sounded quite stilted and formal. In order to address these areas I made a number of changes. I adapted the interview schedule and excluded some of the questions related to recovery. I noted that these questions could have

been influenced by my own interest in hope as part of the recovery model, rather than developing from participants' experiences. When discussions about recovery emerged in later interviews (for example, with participant six) I felt more certain that these reflected participants' own interpretations of hope. In addition, I adapted my interview style. I spent longer at the outset of the interview explaining that the research was conducted as part of my training, and not on behalf of the establishment in which it was conducted. I believe that this helped to reassure participants that they were not being 'tested' on their knowledge and helped them to talk more openly. I also adopted a less formal body posture (such as leaning back in my chair), became more confident to use humour where appropriate and asked for participant feedback about the experience of being interviewed. I found that these changes decreased the perception of a power imbalance. However, some factors that impacted on how relaxed participants felt (such as the use of the Dictaphone) were outside of my control. Indeed I noticed that despite my reassurances about the purpose of the research, several participants spoke much more openly after the Dictaphone had been turned off! However they did agree that their later comments could be included within the analysis. Again, this is acknowledged as a limitation of the methodology employed in the study.

### **'Doing' the Research**

At times the analysis process felt daunting, particularly when the amount of data and potential codes seemed overwhelming. It helped me to return to my epistemological position and remind myself that there were no 'right' or 'wrong' interpretations: as Charmaz (2000, p.524) states: *'data do not provide a window on reality. Rather the 'discovered' reality arises from the interactive process and its temporal, cultural and structural contexts.'*

Transcribing and coding all of the research interviews myself was extremely helpful, as I found that I immersed myself in the data. Mills et al. (2006) suggest that this enables the researcher to embed the narrative of the participants in the final research outcome. As far as possible, adhering to the guidelines suggested by Elliott et al. (1999) helped to ensure the quality

of the analytic process. A methodological critique in light of these guidelines is outlined below.

**Situating the sample.** Participants were asked to provide basic demographic details, which were summarised within the empirical paper in order for the reader to assess the people and situations to whom the results may be applicable (see Paper 2, Appendix 8). However, situating the sample was balanced with the need to protect the anonymity of participants. For example, providing exact ages or specific details regarding the participants' job roles would likely have made them identifiable within the fairly small, close-knit organisation in which they worked.

**Grounding in examples.** In line with suggestions made by Charmaz (1995) I included raw data in the memos that I wrote throughout the analytic process in order to retain the participants' voice and meanings in the final outcome. In addition, I made observations in my journal following each research interview and noted quotes and ideas that had seemed particularly important, and comparisons with data from other interviews (see Appendix 1 for an example of questions I asked myself after each interview). For example, a diagram within my research journal made after the first three interviews captured early ideas about the link between beliefs, values and practices to instil hope:

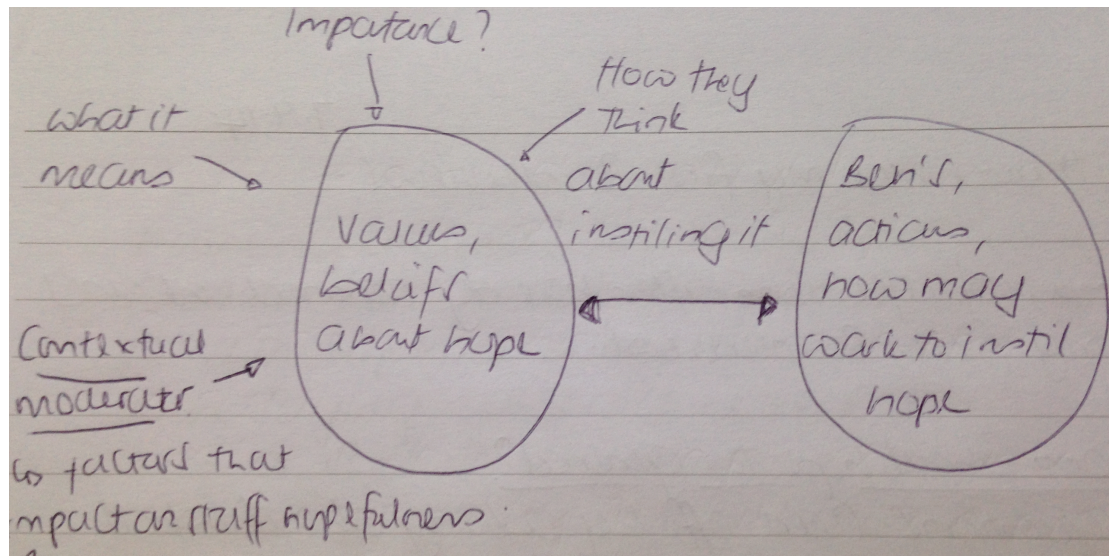


Figure 1 Example of an entry from the research journal

The importance of the theme of *values* was also noted after the interview with participant four:

*"Inspiring hope did not feel contingent on whether/how participants responded to this – it was a principle (right word?), a way of being, a value – Living by values – getting to know the person, their values and goals, again important..."*

As the analysis became more interpretative, I found that this made it easier to return to earlier data in order to compare emerging categories with earlier codes. *Holding on to hope* later emerged as an over-arching category that captured the nurses' view of hope as a personal and professional value.

**Providing credibility checks.** Several steps were taken to assess the credibility of the codes and categories that were developed during the analysis (see Paper 2, p.62). Adapting the interview schedule in order to test out tentative themes prevented me from raising codes to the level of categories too quickly, and from forcing my ideas on to the data. For example, following the initial two interviews a theme emerged around the nurses' *embodying hope* to the service users or providing examples of other

people who embodied a sense of hope. However, the following memo was written after testing out these themes with participants eight and nine:

*“In both cases, participants struggled to understand the concept and therefore, did not seem to relate to it personally. I noted during both interviews that facial expressions showed uncertainty and that I also felt the need to offer an example e.g. giving hope a human form. Recently I have read Charmaz (1990) who speaks of being wary of using ‘jargon’, rather using simple, vivid and direct words to label categories. Originally I thought I would not ask about ‘embodied hope’ directly to participants as it might be too abstract a concept to put across within the interview (which is why I asked about ‘making hope concrete’). However if the label is too abstract to communicate to participants then clearly I need to consider whether it adequately captures their experience!”*

Further theoretical sorting and testing out categories with participant ten resulted in the themes captured within the code *embodied hope* being subsumed within the categories *being the intervention* and the code *developing a positive story*.

Group GT meetings also proved particularly helpful as a forum to share excerpts from transcripts. Research supervisors and peers who were familiar with the methodology were asked to comment on whether the movement from initial to focussed coding was clear and if codes were grounded within the data. An entry in my diary from early January 2015 outlines how I used feedback from the group to move the analysis forward, returning to the data to check out themes I may have overlooked:

*“Sharing parts of my coding has helped me to notice that I have missed stories within the data that participants are telling me, about the impact of instilling hope on them and how they manage this ... I have now coded my last two interviews. This has helped me to clarify some ideas that emerged during the GT group on 8.1.15. The meeting was really a turning point for me. Up until then, I had been sticking tightly to my interview schedule and*



*looking for the 3 areas noted in my data [beliefs about hope, practices to foster hope and challenges] ... some earlier themes (genuine hope; realistic hope; unconditional positive hope) are still important but I am beginning to see that they could be part of something bigger. Themes from my last two interviews have emerged around identity and also the emotional/psychological impact of the work ..."*

**Coherence.** Internal coherence is an evaluation of the extent to which the analysis *'hangs together'* or is non-self-contradictory (Madill, Jordan & Shirley, 2000). A critique of research exploring the ways in which staff in general mental health settings work to develop hope (see Paper 1) revealed that many of the qualitative studies listed factors, themes or categories that developed from the analysis, without an attempt to integrate them into a data-based framework or structure of some kind (Elliott et al., 1999). Within the current study, the development of the overarching category and visual presentation of the model are thought to help the reader make sense of the categories and how they fit together. Presentation of early tentative frameworks within GT meetings (see Paper 2 Appendix 18) helped to establish the credibility of the final model. However, Elliott et al. (1999) also suggest that such models should depict temporal and sequential relationships among categories. Whilst temporality between categories (e.g. *being the intervention* and *doing reasonable hope*) was outlined within the narrative, it is acknowledged that these relationships could have been clearer, potentially with greater saturation of the data.

**Accomplishing general versus. specific research tasks.** The current study provides one interpretation of how nurses in one medium secure unit think about and experience hope. It is therefore acknowledged that further research is required to test the model across forensic settings of different levels of security and with wider members of multi-disciplinary teams within these settings. Whilst recommendations arising from the results have been related to different mental health settings, it is acknowledged that these recommendations are tentative.

**Resonating with readers.** As outlined above, testing out tentative categories with participants during the analysis allowed for an assessment of the extent to which the participants judged the data presented to have accurately represented the phenomena under investigation (Elliot et al., 1999). In particular, I found it particularly helpful to draw on Albas and Albas's recommendations outlined within Charmaz (2014, p.210). These authors suggested that making a note of participants' body language and non-verbal responses helped them to distinguish between '*bland agreement with analysis*' and '*categories that seem to penetrate the real core of the participant's experience*'. For example, following the interview with participant nine I made a note in my research journal that the theme of *embodying hope* had not resonated. This judgement was based on the participant's facial expression (seeming unsure), long pause before responding and a brief agreement with a description of the theme without any fuller description of how it related to them personally.

### **Holding on to Hope: Considering my Values**

As outlined, I believe that my previous experiences and beliefs contributed to the development and design of the research. However, on reflection I also think that the experience of carrying out this piece of research has influenced my values and future clinical practice.

An entry in my journal at the very start of the research process outlined my thoughts regarding the benefits of conducting research with staff. My uncertainty was prompted by two main factors: firstly, the strong narrative about the value and privilege of conducting research with service users; and secondly, a suggestion by one psychologist that doctoral level research with staff represented an 'easy option' against the often challenging process of obtaining ethical procedure and recruiting participants to studies involving service users. Whilst not detracting from the immense value of service user research, as my research journey progressed I became increasingly committed to the value of conducting research with mental health care staff, particularly within the NHS. In the post-Francis (Francis, 2013) time of ever-increasing government and media scrutiny, the pressure on staff working in

healthcare settings to provide high quality, patient-led, compassionate care is great. This pressure is justified based on patient care and safety; however it also requires a '*committed*' workforce who can address the identified '*challenges*' particularly within mental health services (Department of Health; DOH, 2014). Amongst the recommendations made by the Point of Care Foundation report into staff engagement (POCF; 2014) is the need to listen to what staff have to say and pay attention to the emotional consequences of caring for patients. The findings of the current study reflect the emotional impact that working to develop hope with service users can have on practitioners. Despite this, figures from the NHS staff survey (2012; cited in POCF, 2014) found that whilst 74% of staff felt they were able to make improvement suggestions within their organisation, only 26% stated that senior managers acted on it. Just over half of those surveyed (55%) stated that their managers had a positive interest in their health and well-being. My experience of conducting research has led me to strongly believe that research, along with forums such as staff supervision or reflective groups, can provide a space for mental health practitioners to have a voice, reflect on challenges and at a local level, feel valued as a member of an organisation. I also think it provides a means through which to '*translate values into action*' (POCF, 2014) and improve service user experience. Indeed, as the Point of Care Foundation (2014, p.5) state '*it is the experiences of healthcare staff that shape patients' experiences of care, for good or ill, not the other way round*'. Based on our training and skills set, I believe that clinical psychologists are well placed to conduct such research. I was not expecting such a strong value to emerge as a result of my research experience; however I will certainly take this outlook with me into future clinical practice.

Furthermore, the experience of conducting this research has also deepened my appreciation of the need to monitor and nurture my own sense of hope in my clinical practice. I connect to the model of nurses' experience of hope that emerged from the data and can relate it to my own clinical work. It has deepened my appreciation of the need to balance 'being with', attuning to and hearing the client's sense of hopelessness with a focus on the potential for positive change, progress, setting goals and pathways to

achieve them. For me this will require an ability to tolerate the uncertainty of hearing a client's sense of hopelessness and to maintain the client's autonomy despite a pull to jump in and 'rescue' someone from despair. For me, the experience of carrying out this research, and the grounded theory that developed as a result of it, have helped to bring alive the idea of what it means to '*hold on to hope*' for the clients I work with and to acknowledge the emotional impact to myself as a practitioner. My hope is that this study, with perhaps further research to develop and build on it, can play a small part in doing the same for other colleagues in mental health.

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## Appendix 1 Reflective questions following each interview

- Make notes, observations about my general perceptions
- Was I struck by anything in particular?
- What surprised me?
- What did I expect to come up that came up?
- What was different?
- Were any questions hard to answer?
- What were my thoughts about any initial themes?
- What's the story the participant was telling me?